REPORT DOCUMENTATION PAGE

1. AGENCY USE ONLY (leave blank)	2. REPORT DATE	3. REPORT TYPE & DATE COVERED
	November 14, 1996	DoD Instruction 1332.38 DODI-1332.38

4. TITLE & SUBTITLE

Physical Disability Evaluation

5. FUNDING NUMBERS

6. AUTHOR(S)

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7. PERFORMING ORGANIZATION NAME(S) & ADDRESS(ES)

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8. PERFORMING ORGANIZATION REPORT NUMBERS

9. SPONSORING/MONITORING AGENCY NAME(S) & ADDRESS(ES)

10. SPONSORING/MONITORING AGENCY REPORT NUMBERS

11. SUPPLEMENTARY NOTES

12a. DISTRIBUTION/AVAILABILITY STATEMENT

Unclassified, Release unlimited.

12b. DISTRIBUTION CODE

13. ABSTRACT (Maximum 200 Words)

This Instruction implements policy, assigns responsibilities, and prescribes procedures under DoD Directive 1332.18 and Title 10, United States Code for retiring or separating Service members because of physical disability; making administrative determinations under Titles 5 and 37, United States Code for Service members with Service-incurred or Service aggravated conditions; and authorizing a fitness determination for members of the Ready Reserve who are ineligible for benefits under Title 10, United States Code because the condition is unrelated to military status and duty.

14. SUBJECT TERMS

15. NUMBER OF PAGES

77 Pages

16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
Unclassified	Unclassified	Unclassified	

Department of Defense
INSTRUCTION

November 14, 1996
NUMBER 1332.38

ASD(FMP)

SUBJECT: Physical Disability Evaluation

References: (a) DoD Directive 1332.18, "Separation or Retirement for Physical Disability," November 4, 1996
(b) Title 10, United States Code
(c) Sections 3502, 5532, 6303, and 18332 of title 5, United States Code
(d) Sections 206 and 502 of title 37, United States Code
(e) through (k), see enclosure 1

A. PURPOSE

This Instruction implements policy, assigns responsibilities, and prescribes procedures under references (a) and (b) for:

1. Retiring or separating Service members because of physical disability.

2. Making administrative determinations under references (c) and (d) for Service members with Service-incurred or Service aggravated conditions.

3. Authorizing a fitness determination for members of the Ready Reserve who are ineligible for benefits under reference (b) because the condition is unrelated to military status and duty.

B. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense (OSD), the Military Departments (including the Coast Guard when it is operating as a Military Service in the Navy), the Chairman of the Joint Chiefs of Staff, and the Combatant Commands (hereafter referred to collectively as "the DoD Components"). The term "Military Services," as used herein, refers to the Army, the Navy, the Air Force and the Marine Corps.

C. DEFINITIONS

Terms used in this Instruction are defined at enclosure 2.

D. POLICY

It is DoD policy under reference (a) that:

1. The DoD Disability Evaluation System (DES) shall be established to conduct physical disability evaluation in a consistent and timely manner.

2. Members of the Reserve components who are not on a call to active duty of more than 30 days and who are medically disqualified for impairments unrelated to the member's military status and performance of duty shall be referred into the DES solely for a fitness determination upon the request of the member or when directed by the Secretary concerned.

3. The applicable standards for all determinations related to physical disability evaluation shall be consistently and equitably applied, in accordance with 10 U.S.C. (reference (b)), to Active component and Ready Reserve members.

E. RESPONSIBILITIES

1. The Under Secretary of Defense for Personnel and Readiness shall:

a. Exercise cognizance and oversight of the DoD DES.

b. Make the final decision on requests from the Military Departments for exceptions to the standards of this Instruction.

2. The Assistant Secretary of Defense for Force Management Policy, under the Under Secretary of Defense for Personnel and Readiness, shall:

a. Exercise cognizance of laws, policies, and regulations that effect the DES.

b. Issue guidance, as required, to further interpret, implement, and govern the policy and procedures for the four elements of the DES.

c. Establish necessary reporting requirements to monitor and assess the performance of the DES and compliance of the Military Departments with this Instruction and DoD Directive 1332.18 (reference (a)).

d. Coordinate with the Assistant Secretary of Defense for Reserve Affairs concerning the impact of laws and DoD policy on Reserve members who have conditions that are cause for medical disqualification.

e. Coordinate with the Assistant Secretary of Defense for Health Affairs in developing procedures for medical issues pertaining to physical disability evaluation.

f. Review substantive changes proposed by the Military Departments to Departmental policies and procedures for physical

disability evaluation that affect the uniformity of standards for separation or retirement for unfitness because of physical disability or separation of Ready Reserve members for medical disqualification.

g. Develop quality assurance procedures to ensure that policies are applied in a fair and consistent manner.

3. The Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall:

a. Make recommendations for a final decision by the Secretary of Defense on the unfit findings on all officers in pay grade 0-7 or higher and medical officers in any grade who are pending nondisability retirement for age or length of service at the time of their referral into the DES.

b. Review substantive changes proposed by the Military Departments in their supplemental medical standards to enclosure 4 of this Instruction concerning medical conditions that are cause for referral of a member into the DES.

4. The Assistant Secretary of Defense for Reserve Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall coordinate as necessary to ensure that procedures for the DES apply consistently and uniformly to members of the Reserve components.

5. The Secretaries of the Military Departments shall:

a. Ensure that members with conditions that may be cause for referral into the DES are counseled at appropriate stages on the DES process and the member's rights, entitlements, and benefits.

b. Establish a quality assurance process to ensure that policies and procedures established by DoD Directive 1332.18 (reference (a)) and this Instruction are interpreted uniformly.

c. Make determinations on unfitness because of medical disqualification or physical disability; entitlement to assignment of percentage of disability at the time of retirement or separation because of physical disability; and, except as limited by 10 U.S.C. 1216(d) (reference (b)), entitlement to and payment of disability retired and severance pay.

d. Ensure that the record of proceedings for physical disability cases supports the findings and recommendations made.

e. Ensure the Temporary Disability Retired List (TDRL) is managed to meet the requirements of 10 U.S.C. 1210 (reference (b)) for timely periodic physical examinations, suspension of retired pay, and removal from the TDRL.

f. Designate a Military Department representative to serve as the Department representative for the Disability Evaluation System.

g. Ensure all matters raising issues of fraud on the DES by members are investigated and resolved as appropriate.

F. PROCEDURES

See enclosure 3.

G. EFFECTIVE DATE

This Instruction is effective for all MEBs 120 days after the date of this Instruction.

Edwin Dorn
Under Secretary of Defense for
Personnel and Readiness

Enclosures - 5
1. References
2. Definitions
3. Procedures
4. Guidelines Regarding Medical Conditions and Physical Defects That Are Cause for Referral into the Disability Evaluation System
5. Conditions Not Constituting a Physical Disability

REFERENCES, continued

(e) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, Induction", May 2, 1994
(f) Section 104 of title 26, United States Code
(g) DoD Directive 1332.27, "Survivor Benefit Plan", January 4, 1974
(h) DoD Directive 1332.35, "Transition Assistance for Military Personnel," December 9, 1993
(i) DoD Instruction 1332.39, "Application of the Veterans Administration Schedule for Rating Disabilities," November 14, 1996
(j) Sections 801-940 of title 10, United States Code, "Uniform Code of Military Justice"
(k) Sections 101 and 302 of title 38, United States Code

DEFINITIONS

1. Accepted Medical Principles. Fundamental deductions, consistent with medical facts that are so reasonable and logical as to create a virtual certainty that they are correct.

2. Accession Standards. Physical standards or guidelines that establish the minimum medical conditions and physical defects acceptable for an individual to be considered eligible for appointment, enlistment or induction into the Military Services under DoD Directive 6130.3 (reference (e)).

3. Active Duty. Full-time duty in the active Military Service of the United States. It includes:

a. Full-time National Guard Duty.

b. Annual training.

c. Attendance while in active Military Service at a school designated as a Service school by law or by the Secretary of the Military Department concerned.

d. Service by a member of a Reserve component ordered to active duty (with or without his or her consent), or active duty for training (with his or her consent), with or without pay under competent orders.

4. Active Duty for a Period of More than 30 Days. Active duty or full-time National Guard Duty under a call or order that does not specify a period of 30 days or less.

5. Active Reserve Status. Status of all Reserves who are not on an active-duty list maintained under Section 574 or 620 of 10 U.S.C. (reference (b)), except those in the inactive National Guard, on an inactive status list or in the Retired Reserve. Reservists in an active status may train with or without pay, earn retirement points, and may earn credit for and be considered for promotion. In accordance with the Reserve Officer Personnel Management Act (ROPMA), a member in an Active Reserve status must be on the Reserve Active-Status List (RASL)(10 U.S.C. 14002 reference (b)).

6. Active Service. Service on active duty or full-time National Guard duty.

7. Compensable Disability. A medical condition determined to be unfitting by reason of physical disability and which meets the statutory criteria under Chapter 61 of reference (b)for entitlement to disability retired or severance pay.

8. Competency Board. A board consisting of at least three medical officers or physicians (including one psychiatrist) convened to determine whether a member is competent (capable of making a rational decision regarding his or her personal and financial affairs).

9. Death. A determination of death must be made in accordance with accepted medical standards and the laws of the State where the member is located or the military medical standards in effect at an overseas location.

10. Deployability. A determination that the member is free of a medical condition(s) that prevents positioning the member individually or as part of a unit, with or without prior notification to a location outside the Continental United States for an unspecified period of time.

11. Duty Related Impairments. Impairments which, in the case of a member on active duty for 30 days or less, are the proximate result of, or were incurred in line of duty after September 23, 1996, as a result of:

a. Performing active duty or inactive duty training;

b. Traveling directly to or from the place at which such duty is performed; or

c. After September 23, 1996, an injury, illness, or disease incurred or aggravated while remaining overnight, between successive periods for purposes of IDT, at or in the vicinity of the site of the IDT, if the site is outside reasonable commuting distance of the member's residence.

11. Extended Active Duty. Active duty under orders specifying a period of more than 30 days.

12. Final Reviewing Authority. The final approving authority for the findings and recommendations of the PEB.

13. Full and Fair Hearing. A hearing held by a board, before which the Service member has the right to make a personal appearance with the assistance of counsel and to present evidence in his or her behalf.

14. Impairment of Function. Any disease or residual of an injury that results in a lessening or weakening of the capacity of the body or its parts to perform normally, according to accepted medical principles.

15. Inactive Duty Training (IDT). Duty prescribed for Reservists, other than active duty or full-time National Guard Duty, under 37 U.S.C. 206 (reference (d)) or other provision of

law. It does not include work or study in connection with a correspondence course of a Uniformed Service.

16. Instrumentality of War. A vehicle, vessel, or device designed primarily for Military Service and intended for use in such Service at the time of the occurrence of the injury. It may also be a vehicle, vessel, or device not designed primarily for Military Service if use of or occurrence involving such a vehicle, vessel, or device subjects the individual to a hazard peculiar to Military Service. This use or occurrence differs from the use or occurrence under similar circumstances in civilian pursuits. There must be a direct causal relationship between the use of the instrumentality of war and the disability, and the disability must be incurred incident to a hazard or risk of the service.

17. Line of Duty Investigation. An inquiry used to determine whether an injury or disease of a member performing military duty was incurred in a duty status; if not in a duty status, whether it was aggravated by military duty; and whether incurrence or aggravation was due to the member's intentional misconduct or willful negligence.

18. Natural Progression. The worsening of a pre-Service impairment that would have occurred within the same timeframe regardless of Military Service.

19. Nonduty Related Impairments. Impairments of members of the Reserve components that were neither incurred nor aggravated while the member was performing duty, to include no incident of manifestation while performing duty which raises the question of aggravation. Members with nonduty related impairments are eligible to be referred to the PEB for solely a fitness determination but not a determination of eligibility for disability benefits.

20. Office, Grade, Rank, or Rating.

a. Office. A position of duty, trust, authority to which an individual is appointed.

b. Grade. A step or degree in a graduated scale of office or military rank that is established and designated as a grade by law or regulation.

c. Rank. The order of precedence among members of the Armed Forces.

d. Rating. The name (such as "Boatswain's Mate") prescribed for members of an Armed Force in an occupational field.

21. Optimum Hospital and Medical Treatment Benefits. The point of hospitalization or treatment when a member's progress appears

to be stabilized; or when, following administration of essential initial medical treatment, the patient's medical prognosis for being capable of performing further duty can be determined.

22. Performing Military Duty of 30 days or less. A term used to inclusively cover the categories of duty pertaining to 10 U.S.C. 1204 - 1206 (reference (b))(active duty, IDT, and travel directly to and from active duty or IDT).

23. Permanent Limited Duty. The continuation on active duty or in the Ready Reserve in a limited duty capacity of a Service member determined unfit as a result of physical disability evaluation or medical disqualification.

24. Physical Disability. Any impairment due to disease or injury, regardless of degree, that reduces or prevents an individual's actual or presumed ability to engage in gainful employment or normal activity. The term "physical disability" includes mental disease, but not such inherent defects as behavioral disorders, adjustment disorders, personality disorders, and primary mental deficiencies. A medical impairment or physical defect standing alone does not constitute a physical disability. To constitute a physical disability, the medical impairment or physical defect must be of such a nature and degree of severity as to interfere with the member's ability to adequately perform his or her duties.

25. Preponderance of Evidence. That evidence that tends to prove one side of a disputed fact by outweighing the evidence on the other side (that is, more than 50 percent). Preponderance does not necessarily mean a greater number of witnesses or a greater mass of evidence; rather, preponderance means a superiority of evidence on one side or the other of a disputed fact. It is a term that refers to the quality, rather than the quantity of the evidence.

26. Presumption. An inference of the truth of a proposition or fact, reached through a process of reasoning and based on the existence of other facts. Matters that are presumed need no proof to support them, but may be rebutted by evidence to the contrary.

27. Presumption Period. The designated time frame that requires application of the Presumption of Fitness Rule to a member's physical disability evaluation.

28. Proximate Result. A permanent disability the result of, arising from, or connected with active duty, annual training, active duty for training, or inactive duty training (IDT), (etc.) to include travel to and from such duty or remaining overnight between successive periods of inactive duty training. Proximate result is a statutory criteria for entitlement to disability compensation under Chapter 61 of reference (b) applicable to Reserve component members who incur or aggravate a disability

while performing an ordered period of military duty of 30 days or less.

29. Ready Reserve. Units and individual reservists liable for active duty as outlined in Sections 12301 (Full Mobilization) and 12302 (Partial Mobilization) of 10 U.S.C. (reference (b)). This includes members of units, members of the Active Guard Reserve Program, Individual Mobilization Augmentees, Individual Ready Reserve, and the Inactive National Guard.

30. Retention Standards. Physical standards or guidelines which establish those medical conditions or physical defects that may render a Service member unfit for further Military Service and are therefore cause for referral of the member into the DES.30.

31. Service Aggravation. The permanent worsening of a pre-Service medical condition over and above the natural progression of the condition caused by trauma or the nature of Military Service.

PROCEDURES
TABLE OF CONTENTS

PART 1
OPERATIONAL STANDARDS FOR THE DES

A. Overview of the DES. Under the supervision of the Secretary concerned, each DES shall consist of four elements:

1. Medical evaluation by Medical Evaluation Boards (MEBs), Ready Reserve physical examinations, and TDRL periodic physical examinations.

2. Physical disability evaluation by Physical Evaluation Board (PEBs), to include appellate review.

3. Service member counseling.

4. Final disposition by appropriate personnel authorities.

B. Medical Evaluation

1. Purpose. The medical evaluation element of the DES shall document under departmental regulations the medical status and duty limitations of Service members referred into the DES.

2. Type of Evaluation. Medical evaluation is required for personnel undergoing a Medical Evaluation Board when:

a. The Service member is on active duty under orders specifying a period of more than 30 days.

b. The Service member is a Reserve component member referred for a duty related impairment.

c. The member is on the TDRL and due for a periodic physical examination.

Either a physical examination or a MEB is required when a Reserve component member is referred for impairments unrelated to the member's military status and performance of duty (see definition for nonduty-related impairments). Before submission to the PEB, physical examinations accomplished by other than a medical treatment facility (MTF) shall be forwarded through command channels to the medical approving authority designated by the respective Service for review and approval.

3. Content. MEBs, TDRL physical examinations, and Reserve component physical examinations shall document the full clinical information of all medical conditions the Service member has and state whether each condition is cause for referral into the DES. (See enclosure 4 of this Instruction.) Clinical information shall include a medical history, appropriate physical examination, medical tests and their results, medical and surgical consultations as necessary or indicated, diagnoses, treatment, and prognosis. MEBs shall not state a conclusion of unfitness because of physical disability, assignment of

disability percentage rating, or the appropriate disposition under Chapter 61 of 10 U.S.C. (reference (b)).

4. Competency. MEBs and TDRL periodic examinations shall include the results of a competency board when the member has a functional or organic disorder that makes questionable the member's ability to handle his or her personal affairs and to understand and cooperate in MEB and PEB proceedings.

5. TDRL Periodic Examinations. In addition to the requirements specified above, TDRL periodic examinations shall address:

a. An estimate of change since the previous examination.

b. Etiology of all medical impairments diagnosed since the member was placed on the TDRL, to include:

(1) Whether the new diagnosis was caused either by the condition for which the member was placed on the TDRL or the treatment received for such a condition.

(2) If not caused by the condition for which the member was placed on the TDRL, whether the member's medical records document incurrence or aggravation of the condition while the member was in a military duty status; and if so, whether the condition was cause for referral into the DES at the time the member was placed on the TDRL.

c. The stability of the condition. If the condition remains unstable, the report of examination shall address the progress of the disability and a suggested time frame (not to exceed 18 months) for the next examination.

d. A detailed occupational history and an indication of pertinent social and recreational activities, and activities of daily living.

6. Physician's Guide. Physicians who prepare MEBs and TDRL periodic physical examinations for referral for physical disability evaluation are encouraged to use the DVA's Physician's Guide for Disability Evaluation Examinations to describe the nature and degree of severity of the member's condition.

7. Nonmedical Documentation. For cases of members with duty-related impairments, the MTF shall forward to the PEB with the MEB documentation, the documents listed in paragraphs B.7.a through B.7.d., below.

a. A copy of the line of duty determination under subsection D.3. of Part 4.

b. Except in situations of critical illness or injury in which return to duty is not expected, a statement from the member's immediate commanding officer describing the impact of the member's medical condition on the member's ability to perform his or her normal military duties and to deploy or mobilize, as applicable. When the member has been reassigned for medical purposes (for example, to a medical holding unit) the MTF will obtain this statement from the member's former unit commander.

c. Pertinent personnel records, as required by the member's Service, to establish the member's military history.

d. Official document identifying the next-of-kin, court appointed guardian, or trustee when a Service member is determined incompetent. (See subsection B.4. of Part 1.)

8. Ready Reserve Nonduty-Related Impairments. Cases of Ready Reserve members with nonduty-related impairments (see definition) will be referred to the PEB in accordance with Service regulations.

C. Physical Disability Evaluation

1. Purpose. The physical disability evaluation element of the DES shall determine the fitness of Service members with medical impairments to perform their military duties; and for members determined unfit for duty-related impairments, their entitlement to benefits under Chapter 61 of 10 U.S.C. (reference (b)). Physical disability evaluation shall be conducted by PEBs and include the elements in subsections C.2. through C.5., below.

2. Informal PEB. The informal PEB will conduct a documentary review without the presence of the Service member for providing initial findings and recommendations.

3. Formal PEB. Eligible Service members shall be provided a minimum of one opportunity for a formal PEB to fulfill the statutory requirement of Section 1214 of reference (b) for a full and fair hearing when requested by a Service member being separated or retired for physical disability under Chapter 61 of reference (b). The Service member's declination of a formal PEB will be documented by the Physical Evaluation Board Liaison Officer (PEBLO) counselor. Appearance before a formal PEB may be in person, through a designated representative, or via video teleconferencing media.

a. Eligibility

(1) Service members determined unfit by the informal PEB shall be granted a formal PEB upon request.

(2) Active duty and Ready Reserve members determined fit do not have an entitlement to a formal PEB since a

finding of fit does not cause involuntary separation for physical disability.

(3) TDRL members determined fit shall be entitled to a formal PEB since removal from the TDRL represents a change in military status.

b. Directed Formal. A formal PEB may be directed by the final reviewing authority or appropriate designated Military Department authority without regard to the member's election concerning the informal PEB's findings.

c. Issues. At the formal hearing, the member shall be entitled to address any issue that affects the member's benefits under Chapter 61 of 10 U.S.C. (reference (b)); 5 U.S.C. 3502, 5532, 6303, and 8332 (reference (c)); and 26 U.S.C. 104 (reference (f)). Final determination of these issues shall be in accordance with Military Department regulations.

d. Submission of Informal PEB Rebuttal. Service members requesting a formal PEB should be encouraged to submit a rebuttal identifying the issues of disagreement with the informal PEB's findings and recommendations.

e. Hearing Rights. Service members shall have, at a minimum, the following rights before the formal PEB:

(1) The right to personally appear at the formal hearing, which may include video teleconferencing, unless such appearance proves impracticable because the member cannot travel (e.g., the member is incarcerated or incapacitated).

(a) If the member's conduct or statements create a potential security risk to board members and/or other personnel, local security police shall be alerted and appropriate security precautions shall be taken.

(b) Unless the formal hearing is directed by the Military Department concerned, members of the Ready Reserve with nonduty-related impairments are responsible for their personal travel and other expenses.

(2) The right to the assistance of a detailed military counsel provided at no expense to the member or a personal representative provided at no expense to the Service. This right extends to Reserve component members who request a formal hearing pending separation for medical disqualification.

(3) The right to make a sworn statement or an unsworn statement.

(4) The right to remain silent. When the member exercises this right, the member may not selectively respond, but must remain silent throughout the hearing.

(5) The right to introduce witnesses, depositions, documents, sworn or unsworn statements (affidavits) or other evidence in their behalf and to question all witnesses who testify at the hearing. Witnesses who are not members or employees of the Department of Defense and members of the Department of Defense who are not deemed essential witnesses as determined by the PEB attend formal hearings at no expense to the Government.

(6) The right of access to all records and information received by the PEB before, during, and after the formal hearing which may affect the findings of the PEB or appellate review authority.

(7) The right to a written rationale explaining the findings and recommendations of the formal PEB.

(8) The right, upon written request, to a record of the hearing. The respective Service shall determine the format of the record (audio, video, or written transcript).

(9) The right to appeal the findings and recommendations of the formal PEB.

4. Record of Proceedings. A record of proceedings will be prepared to document the findings and recommendations of the PEB.

a. Duty-Related Impairments. The record of proceedings for active duty members and Ready Reserve members referred for duty-related impairments shall document at a minimum:

(1) The determination of fit or unfit. If determined fit, a determination of whether the Service member is deployable may be included if Service regulations require such a determination and deployability is defined and uniformly applied to the office, grade, rank, or rating in both the Active and Reserve components of that Service.

(2) The code and percentage rating assigned an unfitting physical disability in accordance with the VASRD.

(3) The reason an unfitting condition is not compensable.

(a) For all cases with a finding of pre-existing condition without aggravation, the specific accepted medical principle for overcoming the presumption of Service aggravation shall be cited and explained.

(b) For all cases of Reserve component members performing duty of 30 days of less with a finding of not the proximate result of performing duty, the justification shall be documented.

(4) For members being placed on the TDRL or permanently retired, a statement concerning the stability and permanent nature of the physical disability.

(5) Administrative determinations under sections A. and B. of Part 5 of this Instruction.

b. Nonduty-Related Conditions. For members of the Ready Reserve referred for nonduty-related conditions, the record of proceedings shall document only:

(1) The fitness determination.

(2) For members determined fit, a determination of whether the member is deployable if Service regulations require such a determination and deployability is defined and applied to the office, grade, rank, or rating in both the Active and Reserve components of that Service.

c. Rationales. The record of all proceedings for PEB evaluation and changes made as a result of review by subsequent reviewing authority shall include a written rationale (explanation) in support of the findings and recommendations made.

5. Quality Assurance. Quality assurance review shall be conducted as necessary to ensure compliance with the laws, directives, and regulations governing physical disability evaluation.

D. Counseling

1. Purpose. The counseling element of DES shall afford Service members undergoing evaluation by the DES the opportunity to be advised of the significance and consequences of the determinations made and the associated rights, benefits, and entitlements.

2. Topics. Counselors shall counsel on such matters as:

a. The sequence and nature of the steps in processing.

b. Statutory and regulatory rights.

c. Effect of findings and recommendations.

d. Recourse to rebuttals.

e. Estimated retired or severance pay based upon the PEB's findings and recommendations.

f. Probable retired grade.

g. Potential veterans benefits.

h. Post-retirement insurance programs and the Survivor Benefit Plan in accordance with DoD Directive 1332.27 (reference (g)) if appropriate.

i. Applicable transition benefits under DoD Directive 1332.35 (reference (h)).

j. Prior to acting on a Service member's request for a formal PEB, review with the member the applicable standard detailed in the VASRD or DoD Instruction 1332.39 (reference (i)) which would have to be recognized in order to increase the percentage of disability.

3. Ready Reserve Members. Ready Reserve members pending separation for physical disability should be counseled by the MTF Physical Evaluation Board Liaison Officer concerning their rights under the DES as established by section C. of Part 1 and section A. of Part 2.

4. Incompetent Members. When a Service member has been determined incompetent, his or her primary next of kin, or court appointed guardian shall be counseled and afforded the opportunity to assert the rights granted to the Service member, unless prohibited by law.

5. Pre-Separation Counseling. Service members on a call to active duty of more than 30 days shall not be separated or retired because of physical disability prior to completion of pre-separation counseling under reference (h). Though counseling is normally accomplished 90 days before separation, the date of separation or retirement of members determined unfit need not be extended to provide a minimum of 90 days between counseling and separation or retirement.

E. Personnel

1. Purpose. The personnel element of DES shall accomplish disposition of the Service member's case. Specifically, appropriate personnel authorities shall accomplish the functions listed in subsection E.2., below.

2. Functions. The personnel element shall:

a. Issue orders and instructions to implement the determination of the respective Service's final reviewing authority.

b. Serve as approving authority for requests by Service members determined unfit to continue on active duty or in the Ready Reserve in a permanent limited duty status.

c. Manage the TDRL under section B. of Part 6.

F. Time Standards for Case Processing

1. Referral Time Frame. It is not within the mission of the Military Departments to retain members on active duty or in the Ready Reserve to provide prolonged, definitive medical care when it is unlikely the member will return to full military duty. Service members shall be referred into the DES as soon as the probability that they will be unable to return to full duty is ascertained and optimal medical treatment benefits have been attained (see Enclosure 2, Page 2-3, Paragraph 20). All members shall be referred for evaluation within one year of the diagnosis of their medical condition if they are unable to return to military duty.

2. Medical

a. Duty-Related. When a physician initiates a MEB, the processing time should normally not exceed 30 days from the date the MEB report is dictated to the date it is received by the PEB.

b. Nonduty-Related. For cases of Reserve component members referred for solely a fitness determination on a nonduty-related condition, processing time for conduct of MEB or physical examination shall not exceed 90 calendar days.

3. PEB. Upon receipt of the MEB or physical examination report by the PEB, the processing time to the date of the determination of the final reviewing authority as prescribed by the Secretary of the Military Department should normally be no more than 40 days.

4. Imminent Death Processing. When competent medical authority determines that a Service member's death is expected within 72 hours, the member may be referred expeditiously into the DES. To protect the interests of the Government and the Service member, disposition shall be placement on the TDRL provided all requirements under statute, law, and regulation are met. In no case shall a Service member be retired after his or her death or before completion of a required line of duty determination. Determination of death shall be made under the laws of the state where the member is assigned, or under military medical standards when the member is outside the United States.

G. Training and Education. Those Service members designated by the Secretary concerned as primary participants in the DES shall be trained and educated in a timely and continuing manner concerning the policies and procedures of this Instruction. Primary participants in the DES include, but are not limited to, medical officers who prepare MEBs, patient administration officers, disability counselors, PEB and appellate review members, and judge advocates.

PART 2
ELIGIBILITY FOR REFERRAL

A. Criteria for Referral. Service members on active duty or in the Ready Reserve shall be eligible for referral into the DES when the member:

1. Has a medical condition that is cause for referral into the DES as established by enclosure 4 of this Instruction or by the respective Service's supplemental medical standards, and the member has received optimal medical treatment benefits; or

2. Will be unable to return to full military duty within one year of diagnosis of the medical condition; or

3. Was previously determined unfit, continued in a permanent limited duty status, and the period of continuation has expired; and

4. Is not disqualified under section D. of Part 2.

5. Is a member of the regular component of the Armed Forces entitled to basic pay; or any other member of the Armed Forces entitled to basic pay who has been called or ordered to active duty for more than 30 days; or any other member of the Armed Forces, after September 23, 1996, who is on active duty but is not entitled to basic pay under 37 U.S.C. 502(b) (reference (d)) due to authorized absence to participate in an educational program, or for an emergency purpose, as determined by the Secretary concerned.

B. Duty-Related Impairments

1. Service members described in section A., above, who have impairments which, in the case of a member on active duty for 30 days or less, are the proximate result of, or were incurred in line of duty after September 23, 1996, as a result of:

a. Performing active duty or inactive duty training;

b. Traveling directly to or from the place at which such duty is performed; or

c. After September 23, 1996, an injury, illness, or disease incurred or aggravated while remaining overnight, between successive periods for purposes of IDT, at or in the vicinity of the site of the IDT, if the site is outside reasonable commuting distance of the member's residence.

shall be referred into the DES except as provided in sections D. and G., below.

2. Members with duty related impairments as described in paragraphs B.1.a. through B.1.c., above, shall be referred into

the DES for a determination of fitness, and if found unfit, a determination of entitlement to separation or retirement for disability with benefits under Chapter 61 of 10 U.S.C.(reference (b)). The fact that a Service member is unfit for disabilities incurred during the periods designated in paragraphs B.1.a. through B.1.d., above, does not constitute entitlement to disability benefits. (See Part 4 for compensation entitlement criteria.)

C. Nonduty-Related Impairments. Members of the Ready Reserve with nonduty-related impairments, and who are otherwise eligible, will be referred into the DES upon the request of the member or when directed under Service regulations. Referral will be solely for a determination of fitness for duty.

D. Ineligibility for Referral. Service members are ineligible for physical disability evaluation, when:

1. The member's defect is a developmental or constitutional disorder not constituting a physical disability. (See enclosure 5 for a comprehensive listing.)

2. Except as provided under Service regulations, the member is pending an approved, unsuspended, punitive discharge or dismissal.

3. Except as provided under Service regulations, the member is pending separation under provisions that authorize a characterization of service of Under Other Than Honorable (UOTH). This restriction is based on the provisions under which the member is being separated and not on the actual characterization the member receives. For example, because separation for misconduct authorizes a UOTH, a member who is being separated for misconduct with a general characterization is ineligible for referral into the DES except as provided under the regulations of the respective Service.

4. Service regulations should normally provide for referral to the DES of those members designated in subsections D.2. and D.3., above, when the medical impairment or extenuating circumstances may be the cause of the conduct.

E. Members with a Nonwaivered Pre-Existing Condition. Service members who are identified with nonwaivered medical conditions or physical defects that existed prior to service may be administratively separated without referral into the DES when the medical condition meets all the criteria listed in subsections E.1. through E.4., below:

1. The medical impairment is identified prior to or within 180 days of the member's initial entry on active duty or active duty for training or full-time National Guard duty.

2. The medical impairment does not meet accession standards under DoD Directive 6130.3 (reference (e)).

3. The impairment is not a condition that is cause for referral to the PEB under enclosure 4 or Service supplemental medical standards.

4. Service aggravation of the impairment has not occurred. If the Service member contests the "not Service aggravated" determination by the physician recommending separation, the member may request the MEB be forwarded to the PEB for review.

F. Members with Medical Waivers. Provided no aggravation has occurred, Service members who enter the military with a medical waiver may be separated without physical disability evaluation when the responsible medical authority designated by Service regulations determines within 180 days of the member's entry into active service that the waivered condition represents a risk to the member or prejudices the best interests of the Government. Once 180 days have elapsed or the condition is one which causes referral into the DES, the member shall be referred for physical disability evaluation, if otherwise qualified.

G. Waiver of MEB/PEB Evaluation. In certain circumstances, Service members may waive referral to the PEB with the approval of the Secretary of the Military Department. The member must be counseled on the DES process; his or her right to a PEB; and the potential benefits of remaining in an active duty or Active Reserve status for purposes of completing evaluation by the DES. The member must request a waiver in writing, and such request, or an affidavit, must attest that the member has received the counseling described above and declines referral to the PEB. Waiver requests are authorized when either:

1. The MEB reflects that the member's medical condition existed prior to service and was not aggravated by service.

2. Physical disability evaluation requires extension past the date of the member's Service agreement or an approved retirement date, and the member does not consent to retention.

a. Members of a Reserve component on active duty under a call to duty of more than 30 days may continue disability evaluation upon release from active duty provided they maintain a Ready Reserve status. However, they must sign a waiver declining retention on active duty.

b. Members approved for separation under any program which incurs a Reserve obligation and who have conditions which are cause for referral into the DES are prohibited from waiving physical disability evaluation.

3. A Service member reaches the end of active obligated Service and has no remaining Service obligations.

PART 3
STANDARDS FOR DETERMINING UNFITNESS DUE TO PHYSICAL DISABILITY OR MEDICAL DISQUALIFICATION

A. Uniformity of Standards. The standards listed within this Instruction for determining unfitness due to physical disability shall be strictly adhered to, unless exceptions are approved by the Under Secretary of Defense for Personnel and Readiness based upon the unique needs of the respective Military Department.

B. General Criteria for Making Unfitness Determinations

1. A Service member shall be considered unfit when the evidence establishes that the member, due to physical disability, is unable to reasonably perform the duties of his or her office, grade, rank, or rating (hereafter called duties) to include duties during a remaining period of Reserve obligation.

2. In making a determination of a member's ability to so perform his/her duties, the following criteria may be included in the assessment:

a The medical condition represents a decided medical risk to the health of the member or to the welfare of other members were the member to continue on active duty or in an Active Reserve status.

b The medical condition imposes unreasonable requirements on the military to maintain or protect the member.

c The Service member's established duties during any remaining period of reserve obligation.

C. Relevant Evidence. All relevant evidence will be considered in assessing Service member fitness, including the circumstances of referral. To reach a finding of unfit, the PEB must be satisfied that the information it has before it supports a finding of unfitness.

1. Referral Following Illness or Injury. When referral for physical disability evaluation immediately follows acute, grave illness or injury, the medical evaluation may stand alone, particularly if medical evidence establishes that continued service would be deleterious to the Service member's health or is not in the best interests of the respective Service.

2. Referral For Chronic Impairment. When a Service member is referred for physical disability evaluation under circumstances other than as described in subsection C.1., above, evaluation of the member's performance of duty by supervisors as indicated, for example, by letters, efficiency reports, credential reports, status of physician medical privileges, or personal testimony may provide better evidence than a clinical estimate by a physician of the Service member's ability to

perform his or her duties. Particularly in cases of chronic illness, these documents may be expected to reflect accurately a member's capacity to perform.

3. Adequate Performance Until Referral. If the evidence establishes that the Service member adequately performed his or her duties until the time the Service member was referred for physical evaluation, the member may be considered fit for duty even though medical evidence indicates questionable physical ability to continue to perform duty.

4. Cause and Effect Relationship. Regardless of the presence of illness or injury, inadequate performance of duty, by itself, shall not be considered as evidence of unfitness due to physical disability unless it is established that there is a cause and effect relationship between the two factors.

D. Reasonable Performance of Duties

1. Considerations. Determining whether a member can reasonably perform his or her duties includes consideration of:

a. Common Military Tasks. The member, due to physical disability, is unable to reasonably perform the duties of his or her office, grade, rank, or rating (hereafter called duties) to include during a remaining period of Reserve obligation. For example, whether the member is routinely required to fire his or her weapon, perform field duty, or to wear load bearing equipment or protective gear.

b. Physical Fitness Test. Whether the member is medically prohibited from taking the respective Service's required physical fitness test. When an individual has been found fit by a PEB for a condition which prevents the member from taking the Service physical fitness test, the inability to take the physical fitness test shall not form the basis for an adverse personnel action against the member.

c. Deployability. When a Service member's office, grade, rank or rating requires deployability, whether a member's medical condition(s) prevents positioning the member individually or as part of a unit with or without prior notification to a location outside the Continental United States. Inability to perform the duties of his or her office, grade, rank, or rating in every geographic location and under every conceivable circumstance will not be the sole basis for a finding of unfitness. When deployability is used by a Service as a consideration to determine fitness, the standard must be applied uniformly to both the Active and Reserve components of that Service.

d. Special Qualifications. For members whose medical condition causes loss of qualification for specialized duties, whether the specialized duties comprise the member's current duty

assignment; or the member has an alternate branch or specialty; or whether reclassification or reassignment is feasible.

2. General, Flag, and Medical Officers. An officer in pay grade 0-7 or higher or a medical officer in any grade shall not be determined unfit because of physical disability if the member can be expected to perform satisfactorily in an assignment appropriate to his or her grade, qualifications, and experience. Thus, the inability to perform specialized duties or the fact the member has a condition which is cause for referral to a PEB is not justification for a finding of unfitness.

3. Members on Permanent Limited Duty. A member previously determined unfit and continued in a permanent limited duty status or otherwise continued on active duty, will normally be found unfit at the expiration of his or her period of continuation. However, the member may be determined fit when the member's condition has healed or improved so that the member would be capable of performing his or her duties in other than a limited duty status.

4. Overall Effect. A member may be determined unfit as a result of the overall effect of two or more impairments even though each of them, standing alone, would not cause the member to be referred into the DES or be found unfit because of physical disability.

E. Presumption of Fitness

1. Application. Except for Service members previously determined unfit and continued in a permanent limited duty status, Service members who are pending retirement at the time they are referred for physical disability evaluation enter the DES under a rebuttable presumption that they are physically fit. The DES compensates disabilities when they cause or contribute to career termination. Continued performance of duty until a Service member is approved for length of service retirement creates a rebuttable presumption that a Service member's medical conditions have not caused career termination.

2. Presumptive Period. Service members shall be considered to be pending retirement when the dictation of the member's MEB occurs after any of the circumstances designated in paragraphs E.2.a. through E.2.d., below.

a. When a member's request for voluntary retirement has been approved. Revocation of voluntary retirement orders for purposes of referral into the DES does not negate application of the presumption.

b. An officer has been approved for Selective Early Retirement.

c. An officer is within 12 months of mandatory retirement due to age or length of service.

d. An enlisted member is within 12 months of his or her retention control point (RCP)or expiration of active obligated service (EAOS) but will be eligible for retirement at his or her RCP/EAOS.

3. Overcoming the Presumption. The presumption of fitness rule shall be overcome when:

a. Within the presumptive period an acute, grave illness or injury occurs that would prevent the member from performing further duty if he or she were not retiring; or

b. Within the presumptive period a serious deterioration of a previously diagnosed condition, to include a chronic condition, occurs and the deterioration would preclude further duty if the member were not retiring; or

c. The condition for which the member is referred is a chronic condition and a preponderance of evidence establishes that the member was not performing duties befitting either his or her experience in the office, grade, rank, or rating before entering the presumptive period. When there has been no serious deterioration within the presumptive period, the ability to perform duty in the future shall not be a consideration.

F. Evidentiary Standards for Determining Unfitness Because of Physical Disability

1. Factual Finding. A factual finding that a Service member is unfit because of physical disability depends on the evidence that is available to support that finding. The quality of evidence is usually more important than quantity. All relevant evidence must be weighted in relation to all known facts and circumstances which prompted referral for disability evaluation. Findings will be made on the basis of objective evidence in the record as distinguished from personal opinion, speculation, or conjecture. When the evidence is not clear concerning a Service member's fitness, an attempt will be made to resolve doubt on the basis of further objective investigation, observation, and evidence. Benefit of unresolved doubt shall be resolved in favor of the fitness of the Service member under the rebuttable presumption that the member desires to be found fit for duty.

2. Preponderance of Evidence. Findings about fitness or unfitness for Military Service shall be made on the basis of preponderance of the evidence. Thus, if a preponderance (that is, more than 50 percent) of the evidence indicates unfitness, a finding to that effect will be made. If, on the other hand, a preponderance of the evidence indicates fitness, the Service

member may not be separated or retired by reason of physical disability.

PART 4
STANDARDS FOR DETERMINING COMPENSABLE DISABILITIES

A. Overview of Compensable Criteria. Members who are determined unfit under the standards of Part 3 shall be retired or separated with disability benefits when:

1. The physical disability is not the result of the member's intentional misconduct or willful neglect and was not incurred during a period of unauthorized absence or excess leave; and, either:

a. The physical disability was incurred or aggravated while:

(1) A member of a regular component of the armed forces entitled to basic pay.

(2) Any other member of the armed forces entitled to basic pay who has been called or ordered to active duty (other than for training under 10 U.S.C 10148(a)(reference (b)) for a period of more than 30 days.

(3) Any other member of the armed forces, after September 23, 1996, who is on active duty but is not entitled to basic pay by reason of 37 U.S.C. 502(b) (reference (d)) due to authorized absence to participate in an educational program, or for an emergency purpose, as determined by the Secretary concerned; or

b. The physical disability was the proximate result of, or was incurred in line of duty after September 23, 1996, as a result of:

(1) Performing active duty, annual training, active duty for training, or other full time duty under a call or order that specifies a period of 30 days or less.

(2) Performing IDT, to include IDT for points only, other than work or study in connection with a correspondence course of a Uniformed Service.

(3) Traveling directly to or from the place of active duty or IDT.

(4) After September 23, 1996, an injury, illness, or disease incurred or aggravated while remaining overnight, between successive periods of inactive duty training, at or in the vicinity of the site of the inactive duty training if the site is outside reasonable commuting distance from the member's residence.

B. Proximate Result

1. The DES shall make a determination of proximate result on Reserve component cases when:

a. The member is not currently on a call to active duty of more than 30 days; and

b. The unfitting disability was not incurred or aggravated while the member was on an a call to active duty of more than 30 days; and

c. The unfitting disability may have been incurred or aggravated while the member was performing duty of 30 days or less as specified in subsection A.3., above.

2. A disability shall be deemed the proximate result of performing duty when it is a direct consequence of an occurrence during any of the periods of duty specified in subsection A.3., above. All facts, circumstances, and laws on a particular case must be considered.

C. Applicable Statute for Reserve Component Members. A Reserve component member shall be adjudicated under the statutory provisions applicable to his or her duty status at the time of onset or aggravation of the condition for which the member is determined unfit. This means a Ready Reserve member not on extended active duty at the time of his or her referral into the DES, but who is determined unfit for a disability incurred or aggravated while the member was on a call to active duty of more than 30 days, comes under the provisions of 10 U.S.C. 1201 - 10 U.S.C. 1203 and not 10 U.S.C. 1204 - 1206 (reference (b)). In such a situation, "in line of duty while entitled to basic pay" rather than "proximate result" is the applicable statutory requirement for entitlement to disability compensation.

D. Line of Duty Requirements. In the DES, line of duty determinations assist the PEB and appellate review authority in meeting the statutory requirements under Chapter 61 of reference (b) for separation or retirement for physical disability

1. Uses. Line of duty determinations, when required, shall be used during physical disability evaluation to establish the following:

a. Whether the disability was incurred or aggravated while the member was in a duty status.

b. Whether the disability of a Reserve component member was incurred or aggravated while the member was on extended active duty or performing active duty of 30 days or less, while traveling directly to or from the place of active duty or IDT or while remaining overnight, between successive

periods of IDT, at or in the vicinity of the site of the IDT if the site is outside reasonable commuting distance from the member's residence.

c. Relationship of the Line of Duty (LOD) determinations shall be made in accordance with the regulations of the respective Military Department. When an LOD determination is required, the PEB shall consider the findings made for those issues mutually applicable to the LOD and PEB determinations. These issues include whether a condition is pre-existing and whether it is aggravated by Service and any issues of misconduct or negligence. If the PEB determines the LOD determination is contradictory to the evidence, physical disability evaluation may be suspended for a review of the LOD in accordance with Service regulations.

d. Whether the disability is the result of the member's intentional misconduct or willful neglect, or was incurred during a period of unauthorized absence.

2. Relationship of Line of Duty Findings to DES Determinations

a. Line of duty determinations shall be made under the regulations of the respective Military Department. When a line of duty determination is required, the DES shall consider the finding made for those issues mutually applicable to line of duty and DES determinations.

b. When the DES has reasonable cause to believe a line of duty finding appears to be contrary to the evidence, physical disability evaluation shall be suspended for review of the line of duty determination according to Service regulations. The PEB or appellate review authority shall forward the case to the final line of duty reviewing authority designated by the Secretary of the Military Department with a memorandum documenting the reasons for questioning the line of duty finding.

c. The facts recorded in a line of duty investigation shall be considered in making the proximate result determination when applicable to Reserve component cases. However, the DES, not line of duty investigations, determines proximate result.

3. Referral Requirement. When a line of duty determination is required, it shall be accomplished before the forwarding of a Service member's case to the PEB. However, when the case is being processed under imminent death procedures and a line of duty is required, the PEB may commence adjudication of the case pending receipt of the completed line of duty. (Refer to Part 1, subsection F.4.)

4. Presumptive Determinations. The line of duty determination is presumed to be in the line of duty without an investigation in the case of:

a. Disease, except as described in paragraphs E.5.a. and e., below.

b. Injuries clearly incurred as a result of enemy action or attack by terrorists.

c. Injuries while a passenger in common commercial or military carriers.

5. Required Determinations. At a minimum, line of duty determinations shall be required in the circumstances listed in paragraphs D.5.a. through D.5.e., below.

a. Injury, disease, or medical condition that occurs under strange or doubtful circumstances or may be due to the member's intentional misconduct or willful negligence; e.g., motor vehicle accidents.

b. Injury involving the abuse of alcohol or other drugs.

c. Self-inflicted injury.

d. Injury or disease possibly incurred during a period of unauthorized absence.

e. Injury or disease is apparently incurred during a course of conduct for which charges have been preferred under the Uniform Code of Military Justice (UCMJ) (reference (j)).

f. Injury, illness, or disease of a Ready Reserve member while performing duty of 30 days or less or while traveling directly to or from the place at which such duty is performed or while remaining overnight, between successive periods of IDT, at or in the vicinity of the site of the IDT if the site is outside reasonable commuting distance from the member's residence.

E. Evidentiary Standards for Determining Compensability of Unfitting Conditions

1. Misconduct and Negligence. Line of duty determinations concerning intentional misconduct and willful negligence shall continue to be judged by the evidentiary standards established by the Secretary of the Military Department.

2. Presumptions for Members on Ordered Active Duty of More Than 30 days. The presumptions listed in paragraphs E.2.a. through E.2.c. ,below, apply to members on orders to active duty of more than 30 days for purposes of determining whether an impairment was incurred or aggravated while a member was entitled to basic pay.

a. At Time of Entry. A Service member is presumed to have been in sound physical and mental condition upon entering active duty except for medical defects and physical disabilities noted and recorded at the time of entrance.

b. After Entry

(1) Presumption. Any injury or disease discovered after a Service member enters active duty -- with the exception of congenital and hereditary conditions -- is presumed to have been incurred in the line of duty;

(2) Hereditary and/or Genetic Diseases. Any hereditary and/or genetic disease shall be presumed to have been incurred prior to entry into active duty. However, any aggravation of that disease, incurred in the line of duty, beyond that determined to be due to natural progression shall be deemed service aggravated.

c. Presumption of Aggravation. The presumption that a disease is incurred or aggravated in the line of duty may only be overcome by competent medical evidence establishing by a preponderance of evidence that the disease was clearly neither incurred nor aggravated while serving on active duty or authorized training. Such medical evidence must be based upon well-established medical principles, as distinguished from personal medical opinion alone. Preponderance of evidence is defined as that degree of proof necessary to fully satisfy the board members that there is greater than a 50% probability that the disease was neither incurred during nor aggravated by military service.

3. Prior Service Impairments. Any medical condition incurred or aggravated during one period of service or authorized training in any of the Armed Forces that recurs or is aggravated during later service or authorized training, regardless of the time between, should normally be considered incurred in the line of duty provided the condition or subsequent aggravation was not the result of the member's misconduct or willful negligence. In those cases in which the service member reverts to a civilian status after the condition is incurred, the service member must prove by a preponderance of evidence that the medical condition was incurred or aggravated in the line of duty and was not due to intentional misconduct or willful negligence.

4. Conditions Presumed to be Pre-Existing. Occurrence of disease as described in paragraphs E.4.a. and E.4.b., below, shall be presumed to have existed prior to entry into Military Service.

a. Signs or symptoms of chronic disease identified so soon after the day of entry on Military Service (usually within 180 days) that the disease could not have originated in that

short a period will be accepted as proof that the disease manifested prior to entrance into active Military Service.

b. Signs or symptoms of communicable disease within less than the medically recognized minimum incubation period after entry on active Service will be accepted as evidence that the disease existed prior to Military Service.

5. Medical waivers. Members who entered the Service with a medical waiver for a pre-existing condition and who are subsequently determined unfit for the condition shall not be entitled to disability separation or retired pay unless Military Service permanently aggravated the condition or hastened the condition's rate of natural progression. Members granted medical waivers shall be advised of this provision at the time the waiver is granted.

6. Treatment of Pre-Existing Conditions. Generally recognized risks associated with treating preexisting conditions shall not be considered service aggravation.

F. Rating disabilities. When a disability is established as compensable, the disability shall be rated according to the VASRD, as implemented by DoD Instruction 1332.39 (reference (i)) and federal law.

PART 5
ADMINISTRATIVE DETERMINATIONS

A. Administrative Determinations for Purposes of Employment under Federal Civil Service. Physical disability evaluation shall include a recommendation or final decision and supporting documentation on whether the injury or disease that makes the member unfit or that contributes to unfitness was incurred in combat with an enemy of the United States; or was the result of armed conflict; or was caused by an instrumentality of war during a period of war. (These determinations pertain to whether a military retiree later employed under Federal Civil Service is entitled to the following benefits: credit of military service towards a Federal Civil Service retirement under 5 U.S.C. 8332; retention preference under 5 U.S.C. 3502; exemption from the dual compensation provisions of 5 U.S.C. 5532; and credit of military service for Civil Service annual leave accrual under 5 U.S.C. 6303) (reference (c)).

1. Incurred in Combat with an Enemy of the United States (5 U.S.C. 8332)(Reference (c)). The physical disability is a disease or injury incurred in line of duty in combat with an enemy of the United States as defined by the U.S. State Department.

2. Armed conflict (5 U.S.C. 3502, 5532, 6303)(Reference (c)). The physical disability is a disease or injury incurred in the line of duty as a direct result of armed conflict. The fact that a member may have incurred a disability during a period of war or in an area of armed conflict, or while participating in combat operations is not sufficient to support this finding. There must be a definite causal relationship between the armed conflict and the resulting unfitting disability.

a. Armed conflict includes a war, expedition, occupation of an area or territory, battle, skirmish, raid, invasion, rebellion, insurrection, guerrilla action, riot, or any other action in which Service members are engaged with a hostile or belligerent nation, faction, force, or terrorists.

b. Armed conflict may also include such situations as incidents involving a member while interned as a prisoner of war or while detained against his or her will in custody of a hostile or belligerent force or while escaping or attempting to escape from such confinement, prisoner of war, or detained status.

3. Instrumentality of War During a Period of War (5 U.S.C 3502, 5532, 6303, 8332 (Reference (c)). The injury or disease is caused by an instrumentality of war (see definitions in enclosure 2) and incurred in the line of duty during a period of war as defined in 38 U.S.C. 101 and 302 U.S.C. (reference (k))and makes the member unfit. Applicable periods are:

a. World War II. The period beginning 7 December 1941 and ending 31 December 1946 and any period of continuous service performed after 31 December 1946 and before 26 July 1947 if such period began before 1 January 1947.

b. Korea. The period beginning 27 June 1950 and ending 31 January 1955.

c. Vietnam. The period beginning 5 August 1964 and ending 7 May 1975. The "Dominican Intervention" occurred during this period.

d. Persian Gulf. The period beginning 2 August 1990 through date to be prescribed by Presidential proclamation or law.

B. Determinations for Federal Tax Benefits. Physical disability evaluation shall include a determination and supporting documentation on whether the member's physical disability compensation is excluded from Federal gross income under 26 U.S.C. 104 (reference (f)). For compensation to be excluded, the member must meet either of the criteria listed in subsection B.1. or B.2., below.

1. Status. On 24 September 1975 the individual was a member of the Armed Forces, to include the Reserve components, the National Oceanic and Atmospheric Administration (NOAA and formerly the Coast and Geodetic Survey), the U.S. Public Health Service, or was under binding written agreement to become such a member.

a. A Service member who was a member of an Armed Force of another country on that date is entitled to the exclusion.

b. A Service member who was a contracted cadet of the Reserve Officers Training Corps on that date is entitled to the exclusion.

c. Entitlement to the exclusion is based solely on the member's status on that date. A member who separates from the Service after that date and incurs a disability during a subsequent enlistment is entitled to the exclusion.

2. Combat-related. This standard covers those injuries and diseases attributable to the special dangers associated with armed conflict or the preparation or training for armed conflict. A physical disability shall be considered combat-related if it makes the member unfit or contributes to unfitness and was incurred under any of the circumstances listed in paragraphs B.2.a. through B.2.d., below.

a. As a direct result of armed conflict. The criteria are the same as in paragraph A.2., above.

b. While engaged in hazardous service. Such service includes, but is not limited to, aerial flight duty, parachute duty, demolition duty, experimental stress duty, and diving duty.

c. Under conditions simulating war. In general, this covers disabilities resulting from military training, such as war games, practice alerts, tactical exercises, airborne operations, leadership reaction courses; grenade and live fire weapons practice; bayonet training; hand-to-hand combat training; repelling, and negotiation of combat confidence and obstacle courses. It does not include physical training activities, such as calisthenics and jogging or formation running and supervised sports.

d. Caused by an instrumentality of war. Incurrence during a period of war is not required. A favorable determination is made if the disability was incurred during any period of service as a result of such diverse causes as wounds caused by a military weapon, accidents involving a military combat vehicle, injury, or sickness caused by fumes, gases, or explosion of military ordnance, vehicles, or material. However, there must be a direct causal relationship between the instrumentality of war and the disability. For example, an injury resulting from a Service member falling on the deck of a ship while participating in a sports activity would not normally be considered an injury caused by an instrumentality of war (the ship) since the sports activity and not the ship caused the fall. The exception occurs if the operation of the ship caused the fall.

PART 6
TDRL MANAGEMENT

A. Placement on the TDRL. Service members shall be placed on the TDRL when they would be qualified for permanent disability retirement but for the fact that the member's disability is not determined to be of a permanent nature and stable.

1. A disability shall be considered unstable when the preponderance of medical evidence establishes that accepted medical principles indicates the severity of the condition will change within the next five years so as to result in an increase or decrease of the disability rating percentage or a finding of fit.

2. Except for cases processed under imminent death procedures, members with unstable conditions rated at a minimum of 80 percent and which are not expected to improve to less than an 80% rating, shall be permanently retired.

B. TDRL Reevaluation

1. Administrative Finality. During TDRL reevaluation, previous determinations concerning application of any presumption established by this Instruction, line of duty, misconduct, proximate result, and whether a medical impairment was service-incurred or preexisting and aggravated shall be considered administratively final for those conditions for which the member was placed on the TDRL unless there is evidence of fraud; a change of diagnosis that warrants the application of accepted medical principles for a preexisting condition; or correction of error in favor of the member.

2. New Diagnoses. A fitness and compensable determination shall be made on all diagnoses presenting during the period of TDRL evaluation. When a member is determined fit for the condition for which he or she was placed on the TDRL, but unfit for a noncompensable condition incurred while on the TDRL, the member shall be separated from the TDRL without entitlement to disability benefits.

3. Member Medical Records. The Service member shall provide to the examining physician, for submission to the PEB, copies of all his or her medical records (civilian, Department of Veterans Affairs, and all military medical records) documenting treatment since the last TDRL reevaluation.

4. Compensability of New Diagnoses. Conditions newly diagnosed during TDRL periodic physical examinations shall be compensable when:

a. The condition is unfitting; and

b. The condition was caused by the condition for which the member was placed on the TDRL, or directly related to its treatment; or

c. The evidence of record establishes that the condition was either incurred while the member was entitled to basic pay or as the proximate result of performing duty, whichever is applicable, and was an unfitting disability at the time the member was placed on the TDRL. Otherwise, such conditions shall be deemed unfitting due to the natural progression of the condition and noncompensable under Chapter 61 of 10 U.S.C. (reference (b)), although the member may be eligible for benefits for these conditions under the DVA.

5. Current Physical Examination. Service members on the TDRL shall not be entitled to permanent retirement or separation with disability severance pay without a current TDRL or DVA periodic physical examination acceptable to the Service Secretary.

6. Refusal or Failure to Report. As provided under Chapter 61 of reference (b), when a Service member on the TDRL refuses or fails to report for a required periodic physical examination or to provide his or her medical records in accordance with Part 6, Paragraph B.3., his or her disability retired pay may be terminated. If the member later reports for the physical examination, retired pay will be resumed retroactively, to the date the examination was actually performed. If the Service member subsequently shows just cause for his or her failure to report, disability retired pay may be paid retroactively for a period not to exceed one year prior to the actual performance of the physical examination. If the member does not undergo a periodic physical examination after disability retired pay has been terminated, he or she will be administratively removed from the TDRL on the fifth anniversary of placement on the list and separated without entitlement to any of the benefits under reference Chapter 61 of 10 U.S.C. (reference (b)).

7. Priority. TDRL examinations, including hospitalization in connection with the conduct of the examination, shall be furnished on the same priority as given to active duty members.

8. Reports from Non MTFs. MTFs designated to conduct TDRL periodic physical examinations may use reports of medical examinations from medical facilities of another Service, the DVA, other Government Agencies, and authorized civilian medical facilities and physicians to complete the examination. The designated MTF remains responsible for the adequacy of the examination and the completeness of the report. The report must include the information specified in subsection B.4. of Part I.

9. Incarcerated Members. A report of medical examination shall be requested from the appropriate authorities in the case of a Service member imprisoned by civil authorities. In the

event no report, or an inadequate report, is received, documented efforts will be made to obtain an acceptable report. If an examination is not received, disposition of the case shall be in accordance with subsection E.6., above. The member shall be advised of the disposition and that remedy rests with the respective Service's Board for Correction of Military Records.

PART 7
FINAL DISPOSITION

A. Final Decision Authority

1. Secretary of Defense (or Secretary of Transportation). Under 10 U.S.C. 1216 (reference (b)), the Secretary of Defense, or in the case of the Coast Guard, the Secretary of Transportation shall approve the unfit findings on an officer in pay grade 0-7 or higher or a medical officer in any grade who, at the time of referral for physical disability evaluation, was scheduled for nondisability retirement under any provision of reference (b) for age or length of service.

2. Secretary of the Military Department. Except as provided in subsection A.1., above, the Secretary of the Military Department shall have delegable authority to make all determinations consistent with this Instruction regarding unfitness, disability percentage, entitlement to disability severance and retired pay.

B. General Rules Regarding Disposition

1. Retirement. Except for members approved for permanent limited duty (see section C., below), any military member on active duty or in the Ready Reserves who is found to be unfit will be retired, if eligible for retirement, or, if not so eligible, separated. Disciplinary separation or other administrative separations from the Armed Forces are not prevented by this general rule.

a. Members with a disposition of separation for physical disability who have 15 but less than 20 years of service computed under Section 1208 of reference (b) and whose unfitting conditions are not due to the member's intentional misconduct or willful neglect or incurred during a period of unauthorized absence shall be afforded the opportunity to elect separation for physical disability or to apply for, and if approved, nondisability retirement under the Temporary Early Retirement Authority (TERA) under 10 U.S.C. 3911 (reference (b)) during the period of temporary special qualification authority beginning on October 23, 1993, and ending on October 1, 1999. Further, the same opportunity shall be afforded to members recommended for placement on or separation from the TDRL.

b. Ready Reserve members with 15 but less than 20 years of qualifying service under Section 12732 of reference (b) who are to be separated for physical disability other than due to the member's intentional misconduct, willful failure to comply with standards and qualifications for retention, willful neglect or incurred during a period of unauthorized absence shall be afforded the opportunity to elect either separation for physical disability or early qualification for retired pay at age 60 under Section 12731a of reference (b) during the period of temporary

special retirement qualification authority beginning on October 23, 1992, and ending on October 1, 1999. Further, the same opportunity shall be afforded to Ready Reserve members recommended for placement on or separation from the TDRL.

2. Fit off the TDRL. Service members determined fit as a result of TDRL reevaluation shall be processed as described below.

a. Appointment and/or Enlistment. Upon the Service member's request and provided he or she is otherwise eligible, the member shall be appointed or enlisted in the applicable grade and component as outlined in Section 1211 of reference (b).

b. Recall to Active Duty. Subject to paragraph B.3.c., below:

(1) Regular Component Members. Subject to their consent, Regular officers and enlisted members shall be recalled to duty, provided they are otherwise eligible and were not required to be separated under law or regulation at the time they were placed on the TDRL. They shall be deemed medically qualified for those conditions on which a finding of fit was determined. Any new condition arising between DES evaluation and recall must meet the respective Service's medical standards for retention.

(2) Reserve Component. Subject to their consent, Reserve component officers, warrant officers and enlisted members shall be reappointed or reenlisted as a Reserve for service in his or her Reserve component under 10 U.S.C. 1211 (reference (b)).

c. Separation. In accordance with Section 1210(f) of reference (b), members required to be separated or retired for nondisability reasons at the time they were referred for physical disability evaluation and placed on the TDRL shall, if determined fit, be separated or retired, as applicable.

d. Termination of TDRL status. Termination of TDRL status and retired pay shall be as outlined in 10 U.S.C. 1211 (reference (b)).

C. Continuance of Unfit Members on Active Duty or in the Ready Reserves. When, with the recommendation of the Service component, the Secretary of the Military Department concerned determines that an unfit Service member's service obligation, skill, or experience justifies the continuance of that Service member on active duty or in active status in a permanent limited duty status, the Service member may be retained as an exception to the general policy rule in subsection B.1, above.

D. Transition benefits. Active component members and Reserve component members who are on active duty are entitled to the transition benefits established by DoD Directive 1332.35

(reference (h)) when these members are being separated or retired for physical disability unless waived by DoD or prohibited by federal law.

E. Dispositions for Unfit Members

1. Permanent Disability Retirement. Retirement is directed under Section 1201 or 1204 of reference (b) when the member is unfit for a permanent and stable compensable physical disability under the standards of this Instruction; and

a. The member has at least 20 years of service computed under Section 1208 of reference (b); or

b. The total disability rating is at least 30 percent under the VASRD.

2. Placement on the TDRL. Retirement is directed under Section 1202 or 1205 of reference (b) when the requirements for permanent disability retirement are met except the physical disability is not permanent and stable.

3. Separation with disability severance pay

a. Criteria. Separation is directed under Section 1203 or 1206 of reference (b) when the member is unfit for a compensable physical disability determined under the standards of this Instruction, and the requirements listed in subparagraphs E.3.a.(1) and E.3.a.(2), below, are met. Stability is not a factor for this disposition.

(1) The member has less than 20 years of service computed under Section 1208 of reference (b); and

(2) The disability is rated at less than 30 percent, to include 0 percent.

b. Active Service. Under 10 U.S.C. 1212 (reference (b)), a part of a year of active service that is six months or more is counted as a whole year, and a part of a year that is less than six months is disregarded. Thus, members with less than six months of service at the effective date of their disability separation receive no disability severance pay.

c. Transfer to Retired Reserve. Under Section 1209 of reference (b), Ready Reserve members who have completed at least 20 qualifying years of Reserve service and who would otherwise be qualified for retirement may forfeit disability severance pay and request transfer to an Inactive Status List for the purpose of receiving nondisability retired pay at age 60. When disability severance pay is accepted, the member forfeits all rights to receive retired pay under Chapter 1223 of reference (b) at age 60. There are no provisions under reference (b) to repay

disability severance pay for the purpose of receiving retired pay.

d. Ready Reserve Early Qualification for Retired Pay. Under 10 U.S.C. 12731 of reference (b), Reserve component members with at least 15, and less than 20, years of qualifying service and who would otherwise be qualified for retirement may waive disability disposition and request early qualification for retired pay until 1 October, 1999, unless the provisions of this statute are extended or rescinded.

4. Separation under Chapter 61 of 10 U.S.C. (Reference (b)) Without Entitlement to Benefits. Discharge is directed under Section 1207 of reference (b) when the member is unfit for a disability incurred as a result of intentional misconduct, willful neglect, or during a period of unauthorized absence.

5. Discharge Under Other Than Chapter 61 of 10 U.S.C.(Reference (b)). An unfit member is directed for discharge under other provisions of reference (b) when the member is not entitled to physical disability compensation due to the circumstances listed in paragraphs E.5.a. through E.5.d., below.

a. The disability existed prior to service and was not permanently aggravated by service; or

b. The disability was incurred while the member was in an excess leave status; or

c. The disability was incurred by a Reserve component member performing duty of 30 days or less, but the disability was determined not the proximate result of performing such duty; or

d. The medical impairment of a Ready Reserve member is nonduty-related; disqualifies the member for retention in the Reserve components; and either the member does not request referral into DES for a fitness determination or such referral results in a finding of unfit. Disposition of such members shall be under appropriate Service regulations.

If a member not entitled to physical disability compensation under Chapter 61 of reference (b) due to the circumstances listed above has six years or more, but less than 20 years of active service, immediately prior to that discharge, the member shall be entitled to separation pay as an involuntary discharge or release from active duty as prescribed by Section 1174 of reference (b), unless the Secretary concerned determines that the conditions under which the member is discharged do not warrant payment of such pay.

6. Revert With Disability Benefits. This disposition is used to return to retired status a retiree recalled to active duty who was:

a. Previously retired for physical disability; or,

b. Determined unfit during the period of recall. For members previously retired for age or years of service, the compensable percentage of disability must be 30 percent or more to receive disability benefits.

GUIDELINES REGARDING MEDICAL CONDITIONS AND PHYSICAL DEFECTS THAT ARE CAUSE FOR REFERRAL INTO THE DISABILITY EVALUATION SYSTEM

A. GENERAL

1. This enclosure provides a listing, mainly by body system, of medical conditions and physical defects which are cause for referral into the Disability Evaluation System (DES).

a. This listing is not all inclusive.

b. A service member who has one or more of the listed conditions or physical defects is not automatically unfit and therefore may not qualify for separation or retirement for disability.

2. Individual Secretaries of the Military Departments may, consistent with this Instruction, modify these guidelines to fit their particular needs. These modifications may include conditions or defects, individually or in combination that:

a. Significantly interfere with the reasonable fulfillment of the purpose of the individual's employment in the Military Service;

b. May seriously compromise the health or well-being of the individual if he or she were to remain in the Military Service. This may involve dependence on certain medications, appliances, severe dietary restrictions, or frequent special treatments, or a requirement for frequent clinical monitoring.

c. May prejudice the best interests of the Government if the individual were to remain in the Military Service.

3. Any condition that appears to significantly interfere with performance of duties appropriate to a service member's, office, grade, rank or rating will be considered for MEB evaluation. The MEB shall:

a. Confirm the medical diagnosis(es).

b. Document the Service member's current medical condition to include treatment status and potential for medical recovery.

c. Review each case based on relevant facts.

d. Bolded and bracketed evaluation procedures and/or data of special importance to the assessment process shall be contained in the MEB.

e. A suggested annotated format for the MEB report is at Attachment I of this Instruction.

f. If optimal medical treatment has been received in accordance with service specific guidelines, refer to the PEB.

B. MUSCULOSKELETAL SYSTEM

1. Upper Extremity

a. The ability to pinch, grasp, or grip is prevented by disease, residuals of disease, acute injury, or chronic residuals of acute injury to the hand or fingers.

b. Amputation of a part or whole of the upper extremity.

c. Recurrent dislocation (not subluxation) when not surgically correctable.

d. Ranges of Joint Motion (ROM): Motion that is less than the measurements listed below. (Measurements should be validated by three (3) measurements that agree at the 5% level. The measuring instrument should be noted. Both active and passive ROM should be listed. When a normal paired extremity is present a comparison of the ROM of the normal to the impaired extremity should be included (See Plate I)).

(1) Shoulder: Flexion or abduction to at least 90 degrees.

(2) Elbow and/or Forearm: Flexion to 100 degrees or extension to 60 degrees. Pronation and/or Supination arc to at least 80 degrees.

(3) Wrist: A total of at least 15 degrees flexion plus extension.

(4) Hand: The motion at each of the three finger joints, when added together, must reach 135 degrees of active flexion or 75 degrees of active extension, in two or more fingers of the same hand. The thumb must be able to be opposed to at least two fingertips.

2. Lower Extremity

a. Disease, residual of disease, acute injury, or residual of injury that interferes with ambulation or the wearing of military shoes and/or boots for a period in excess of 180 days.

b. Any documented condition that precludes the ability to run or walk without a perceptible limp.

c. Shortening of an extremity that exceeds two inches (5 cms).

d. Feet: Any condition that prevents walking, running, or normal weight bearing.

e. Knee: Internal derangement of the knee when there is residual instability following remedial measures such as surgery or physical therapy.

f. Joint Ranges of Motion (ROM): Motion that is less than the measurements listed below. (Measurements should be validated by three (3) measurements that agree at the 5% level. The measuring instrument should be noted. Both active and passive ROM should be listed. When a normal paired extremity is present a comparison of the ROM of the normal to the impaired extremity should be included (See Plate II).)

(1) Hip: Flexion to 90 degrees, or extension to 0 degrees.

(2) Knee: Flexion to 90 degrees, or extension to 15 degrees.

(3) Ankle: Dorsiflexion to 10 degrees, or plantar flexion to 10 degrees.

3. Inflammatory Condition. Any inflammatory condition involving the bones, joints, or muscles of the extremities, that after accepted therapy, prevents the military member from performing the preponderance of duties assigned.

4. Prosthetic Replacement. Total or partial prosthetic replacement of a major joint, i.e., hop, knee, shoulder.

5. Muscles. Atrophy of, loss of substance of, direct injury to (or residuals thereof) one or more muscles or muscle groups that prevents satisfactory use of the upper or lower extremity. (Does not include muscular changes secondary to neurological disorders. Refer to section on the Nervous System.)

6. Tendon and/or Ligament Transplantation: If restoration of function is not sufficient to adequately perform the preponderance of duties required.

7. Spine

a. Congenital Disorders. (e.g., Spina Bifida, Coxa Vara, Spondylolysis/Spondylolisthesis, Kyphosis, Scoliosis) When more than mild symptoms cause a deterioration in performance of required duties.

b. Acquired Disorders

(1) Fractures requiring spinal cord decompression with residual neurological deficit or loss of mobility due to fusion.

(2) Spondylolysis and/or Spondylolisthesis requiring fusion with loss of mobility.

(3) Herniation of nucleus pulposus when more than mildly symptomatic, with demonstrated neurological involvement; or subsequent surgical treatment does not provide symptomatic relief sufficient for performance of duties.

8. Skull. Significant loss of substance without prosthetic replacement, or with prosthetic replacement in the presence of significant residuals.

9. Fibromyalgia. This condition must meet the definition as put forth by the American College of Rheumatology in 1990.

C. Organs of Special Senses

1. Eyes

a. Eye Disease. Active eye disease or any progressive organic disease or degeneration, regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual fields such that distant visual acuity is significantly affected or the field of vision of the better eye is less than 40 degrees. (See "Visual Acuity" below.)

b. Visual Acuity. Visual acuity that cannot be corrected with ORDINARY SPECTACLE LENSES, to at least 20/40 in one eye and 20/100 in the other eye, or 20/20 in one eye and 20/400 in the other eye, or an eye has been enucleated.

c. Aniseikonia. With subjective eye discomfort, neurologic symptoms, sensations of motion sickness, functional difficulties and difficulties in distinguishing forms, and not corrected by standard optical lenses.

d. Binocular Diplopia. When not surgically or optically correctable, that is severe, and constant.

e. Bilateral Hemianopsia. Any type that is permanent, and based on an organic defect.

f. Night Blindness. Of such a degree that precludes unassisted night travel.

g. Vision Fields

(1) Visual fields with bilateral concentric constriction to less than 40 degrees.

(2) Visual field in better eye is less than 40 degrees.

2. Ears and/or Hearing

a. Ears

(1) Otitis Externa, chronic, severe, requiring frequent and prolonged treatment.

(2) Mastoiditis requiring frequent and prolonged treatment; or, subsequent to mastoidectomy there is constant drainage from the mastoid cavity.

(3) Meniere's syndrome or labyrinthine disorders of sufficient severity to interfere with satisfactory performance of duties.

(4) Otitis Media, chronic, resistant to conventional therapy interfering with satisfactory performance of duties.

b. Hearing

(1) Unaided hearing loss that adversely effects safe and effective performance of duty.

(2) In the assessment of hearing, when the unaided average loss in the BETTER ear is 35 Db (ANSI) or more in the normal speech range (pure tone audiometric values at the 1000, 2000, 3000, 4000 hertz) the individual will be evaluated at an audiology and speech center. Referral to an MEB will be based on the test that most accurately reflects the degree of hearing loss.

(3) Trained and experienced personnel will not be categorically disqualified if they are capable of effective performance of duty with a hearing aid. Speech discrimination test results should be included.

D. SYSTEMIC DISEASES

1. Definition. Any acute or chronic condition that affects the body as a whole (systemic) and interferes with the successful performance of duty, or requires medication for control, or needs frequent monitoring by a physician, or that requires geographic assignment limitations or requires a temporary limitation of duty exceeding 180 days, or a permanent limitation of duty that effects the whole body (systemic).

a. Infectious

(1) Systemic Mycoses, e.g. Blastomycosis.

(2) Tuberculosis. Pulmonary or generalized.

(3) Leprosy.

(4) AIDS.

(5) Sexually Transmitted Diseases

(6) HIV Seropositivity

b. Arthritis

(1) Rheumatoid Arthritis.

(2) Spondyloarthropathy.

(a) Ankylosing spondylitis.

(b) Reiter's Syndrome.

(c) Psoriatic Arthritis.

(d) Arthritis associated with inflammatory bowel disease.

(e) Whipple's disease.

c. Other Systemic Diseases

(1) Amyloidosis.

(2) Sarcoidosis. Progressive, not responsive to therapy.

(3) Panniculitis. Relapsing, febrile, nodular.

(4) Myasthenia Gravis.

(5) Porphyria cutanea tarda.

(6) Systemic Lupus Erythematosus.

(7) Sjogren's Syndrome.

(8) Chronic Fatigue Syndrome.

(9) Myopathy. Inflammatory, metabolic, hereditary.

(10) Progressive systemic sclerosis.

(11) Systemic vasculitis.

(12) Hypersensitivity angiitis. Resistant to treatment and more than mildly symptomatic.

(13) Behcet's syndrome.

(14) Adult-onset Still's disease.

(15) Mixed connective tissue disease (overlapping syndromes).

E. RESPIRATORY SYSTEM

1. Upper Airway

a. Sinusitis. Sinusitis or rhinitis (atrophic), with Suppuration. Unresponsive to conventional therapy.

b. Larynx

(1) Obstructive edema of the glottis requiring tracheostomy.

(2) Vocal cord paralysis seriously interfering with speech or airway.

(3) Stenosis of such a degree as to cause respiratory embarrassment on moderate exertion.

c. Trachea. Stenosis or narrowing of such a degree as to cause respiratory embarrassment on moderate exertion.

2. Lower Airway. (Rating is usually based upon Pulmonary Function Tests (PFTs) measuring residual function. Tests should be validated (two of studies agreeing at the 5% level). In addition, studies before and after medication should be done).

a. Infection

(1) Pulmonary Tuberculosis.

(a) If treatable but more than 15 months will be required before service member can be returned to active duty.

(b) Cases unresponsive to therapy.

(2) Histoplasmosis, blastomycosis, toxoplasmosis, or other mycosis not responding to accepted therapy.

b. Asthma. (A clinical syndrome characterized by cough, wheeze, dyspnea and physiological evidence of reversible air flow obstruction or airway hyperreactivity that generally persists over six(6) months. Reversible air flow obstruction is defined as more than 15% increase in FEV1 following administration of an

inhaled Bronchodilator. Airway hyperreactivity is defined as the exaggerated decrease in air flow induced by a standard methacholine challenge test. Chronic asthma requires the regular use of medication to allow the individual to perform the preponderance of military duties.)

c. Bronchiectasis or bronchiolectasis. Cylindrical or saccular with residuals requiring repeated medical care.

d. Bronchitis. Chronic, severe, recurrent unresponsive to repeated medical care.

e. Atelectasis. Unresponsive to conventional therapy requiring repeated medical care.

f. Pulmonary Sarcoidosis. Progressive, unresponsive to conventional therapy.

g. Pneumoconiosis. Severe, with dyspnea on moderate exertion.

h. Cystic disease of the lung

i. Pulmonary Emphysema

j. Pulmonary Fibrosis

k. Residuals. Residuals of pneumothorax, hemothorax, empyema, or residuals of operative procedures on the lungs or chest wall.

l. Bronchial Stenosis

m. Diaphragmatic Dysfunction. Diaphragmatic dysfunction resulting in dyspnea on minimal exertion, not responsive to therapy.

n. Lung Transplant.

F. CARDIOVASCULAR SYSTEM

1. Heart. (In assessing the function of the heart, various functional therapeutic classifications (FTC) may be used as standards (New York Heart Association, Canadian Cardiovascular Society, etc.) Each of the Cardiac conditions should be given an FTC.)

a. Arteriosclerotic Heart Disease.

(1) Coronary Artery Disease.

(a) Angina Pectoris.

(b) Myocardial Ischemia.

(c) Myocardial Infarction.

(d) Congestive Heart Failure.

b. Inflammatory.

(1) Endocarditis.

(2) Pericarditis, chronic or repetitive.

(3) Rheumatic Heart Disease.

(4) Syphilitic Heart Disease.

c. Cardiac Arrhythmias and/or Pacemakers. (See also para A.2.b., above)

(1) Supraventricular Arrhythmias. When life threatening or symptomatic enough to interfere with duty performance.

(2) Heart Block (second or third degree AV block) and chronic symptomatic bradyarrhythmias with poor response to conventional therapy.

(3) Ventricular Arrhythmias. When potentially life threatening or symptomatic enough to interfere with the performance of duty.

(4) Residuals of Sudden Cardiac Death Syndrome Following Successful Resuscitation.

(5) Near or recurrent syncope of cardiac origin.

(6) Permanent indwelling pacemakers or defibrillators or other permanent antitachycardia devices.

d. Hypertrophic Cardiomyopathy.

e. Dilated Cardiomyopathy.

f. Myocardial Disease.

g. Valvular Heart Disease.

h. Hypertensive Cardiac Disease.

i. Post Operative or other invasive procedures involving the heart, pericardium, or vascular system.

(1) Permanent Prosthetic Valve Implantation.

(2) Coronary Artery Revascularization.

(3) Coronary or Valvular Angioplasty or Plaque removal.

(4) Cardiac Arrhythmia Ablation procedures, unless free of unfitting symptoms and signs.

(5) Reconstructive Cardiovascular surgery.

(6) Cardiac Transplant.

k. Any cardiovascular disorder requiring chronic drug therapy in order to prevent the occurrence of potentially fatal or severely symptomatic events that would interfere with duty performance.

2. Vascular System

a. Arteriosclerosis Obliterans. Evidence of arterial disease such as intermittent, ischemic rest pain, or gangrenous/ulcerative skin changes of a permanent nature. Involvement of one or more organs or systems, or anatomic region with symptoms of arterial insufficiency.

b. Major Cardiovascular Anomalies.

(1) Coarctation of the Aorta.

(2) Aneurysm of any major vessel.

c. Periarteritis Nodosa.

d. Chronic Venous Insufficiency.

e. Raynaud's Syndrome.

f. Thromboangiitis Obliterans. With claudication (see F.2.a., above).

g. Recurrent Thrombophlebitis.

h. Varicose Veins. Severe and symptomatic despite conventional therapy.

i. Any vascular reconstruction.

3. Miscellaneous Conditions.

a. Cold Injury.

(1) Frostbite, if significant or with residuals.

(2) Trench foot.

(3) Hypothermia.

b. Erythromyalgia.

c. Hypertensive Cardiovascular and/or Vascular disease.

(1) Diastolic pressure consistently greater than 100mm Hg following adequate therapy; and/or,

(2) Associated changes in the brain, heart, kidney, or optic fundi.

d. Neurocirculatory Syncope

4. Anticoagulant Therapy. When chronically required.

G. GASTROINTESTINAL SYSTEM

1. General. Any organic condition of the Gastrointestinal System that prevents adequate maintenance of the service member's nutritional status, or requires significant dietary restrictions.

2. Inflammatory and/or Infectious Conditions.

a. Esophagitis.

(1) Infectious (e.g., Candidiasis).

(2) Reflux. When not responsive to therapy.

(3) Hiatal hernia. When not responsive to therapy.

b. Gastritis. When not responsive to therapy.

c. Hepatitis.

(1) Persistent symptoms or persistent evidence of impaired liver function.

(2) Inability to serve as a blood donor.

(3) Persistence of biochemical markers indicating chronicity.

d. Pancreatitis, chronic, with residuals (such as malabsorption/glucose abnormality due to enzyme deficiency), or recurrent.

e. Regional Enteritis.

f. Ulcerative Colitis.

g. Proctitis, significantly symptomatic.

h. Intra-abdominal abscess. When unresponsive to therapy.

i. Hepatic abscess. When unresponsive to therapy.

3. Obstructive Conditions

a. Congenital.

(1) Diverticula.

(2) Webs.

(3) Strictures.

b. Acquired.

(1) Diverticula.

(2) Webs.

(3) Strictures.

(4) Peritoneal Adhesive Bands.

4. Dysfunctional Conditions

a. Achalasia of the Esophagus.

b. Biliary Dyskinesia.

c. Cirrhosis. Moderate with evidence of portal hypertension, abdominal veins and/or impaired liver function and/or significant impairment of health.

d. Ulcers (Duodenal, Gastric, Intestinal) when there are complications or residuals.

e. Postgastrectomy and/or Dumping Syndromes.

f. Permanent Gastrostomy, Enterostomy, Ileostomy, Colostomy, Pancreatoenterostomy.

g. Total Gastrectomy, Pancreatectomy

h. Fecal Incontinence.

5. Abdominal Wall Defects. Hernia, recurrent, when repair is contraindicated and the defect interferes with duty performance. This includes removal, e.g., post mastectomy reconstructive surgery.

H. GENITOURINARY SYSTEM

1. Urinary System. (There are three general dysfunctions of the urinary system: Renal Dysfunction, Voiding Dysfunction, Urinary Tract Infection. Some conditions involve a combination.)

a. Renal Dysfunction. (Medical workup will include Creatinine Clearance to quantitate the degree of dysfunction. (See Table 5 of DoD Instruction 1332.39(reference (i))

(1) Retained Renal Calculus. When resulting in recurrent symptoms, abnormal renal function, or recurrent infection and is not correctable by therapy.

(2) Cystic Kidney, when renal function is impaired or the focus of recurrent infection.

(3) Glomerulonephritis.

(4) Hydronephrosis. When not correctable.

(5) Hypoplasia of the kidney. When symptomatic (high blood pressure, frequent infections, e.g.).

(6) Chronic Nephritis.

(7) Nephrosis.

(8) Stricture of the Ureter, if clinically significant and not correctable.

(9) Residuals of Ureteral Operations, including:

(a) Ureterocolostomy and/or Ureterosigmoidostomy.

(b) Ureterocystostomy.

(c) Ureteroileostomy.

(d) Ureteroplasty.

(10) Pyeloplasty, with significant residuals.

(11) Nephrectomy. When there are complications with the remaining kidney.

(12) Nephrostomy, Pyelostomy, Ureterostomy. When there is persistent drainage.

(13) Renal Transplant.

(a) Recipient.

(b) Donor. If there is malfunction of the remaining kidney.

(14) Pyelonephritis, if chronic.

b. Voiding Dysfunction

(1) Cystitis, when complications or residuals preclude satisfactory performance of duty.

(2) Urinary Incontinence, if unresponsive to treatment.

(3) Neurogenic Bladder.

(4) Epispadias. When there is an inability to perform required duty due to soilage or recurrent infection.

(5) Stricture of the Urethra, not amenable to treatment.

(6) Cystectomy

(7) Cystoplasty. When residual urines are greater than 50cc and/or there is refractory infection.

(8) Urethrostomy.

c. Urinary Tract Infection

(1) Chronic Urethritis.

(2) Chronic Pyonephrosis/Pyelonephritis.

(3) Perirenal Abscess.

(4) Cystoplasty. When there is refractory infection.

2. Female Genitourinary Conditions

a. Dysmenorrhea. When severity is such that duty performance is affected.

b. Endometriosis. When the severity is such that duty performance is affected.

c. Menopausal Syndrome. When constitutional symptoms prevent duty performance.

d. Chronic Pelvic Pain. When the severity is such that duty performance is affected.

e. Hysterectomy. When residual complications preclude satisfactory performance of duty.

f. Oophorectomy. When residual symptoms preclude satisfactory duty performance.

I. HEMIC AND LYMPHATIC SYSTEMS

1. Anemia. When symptomatic and not responsive to therapy.

2. Hemolytic Crises. When complicated, chronic, and symptomatic.

3. Leukopenia. When not responsive to therapy or when therapy is prolonged, or when complicated by recurrent infections.

4. Polycythemia. When unresponsive to therapy.

5. Purpura or Bleeding disorders.

6. Chronic Anticoagulation Therapy.

7. Hypercoagulable states with thromboembolic disease.

8. Indwelling Filter to prevent embolic phenomena.

9. Leukemia, or history thereof.

10. Lymphomas, or history thereof

a. Hodgkin's.

b. Non-Hodgkin's.

J. SKIN AND CELLULAR TISSUES

1. When conditions are severe, unresponsive to therapy, and interfere with the satisfactory performance of duty, wearing of the uniform, or using military equipment.

2. Systemic Conditions, including:

a. Amyloidosis.

b. Dermatomyositis.

c. Dermatographism.

d. Eczema.

e. Chronic Lymphedema.

f. Erythema Multiforme.

g. Hyperhidrosis.

h. Leukemia Cutis or Mycosis Fungoides.

i. Neurofibromatosis.

j. Psoriasis.

k. Parapsoriasis.

l. Scleroderma.

m. Pemphigus.

n. Exfoliative Dermatitis.

o. Epidermolysis Bullosa.

p. Urticaria.

q. Lichen Planus.

r. Cutaneous Lupus Erythematosus.

3. Localized Conditions

a. Radiodermatitis. Particularly if there is malignant degeneration not amenable to therapy.

b. Intractable Plantar Keratosis.

c. Scars and Keloids. Locally extensive and adherent so as to interfere with the function of a body part or prevent the wearing of the uniform.

d. Xanthoma.

e. Cysts and Tumors. When not amenable to accepted therapy.

f. Atopic Dermatitis.

g. Ulcers of the skin. When not responsive to therapy.

4. Infectious Conditions

a. Acne, Cystic, Severe. When unresponsive to therapy.

b. Dermatitis Herpetiformis.

c. Panniculitis.

d. Cutaneous Tuberculosis.

e. Elephantiasis.

5. Other Chronic Skin Disorders.

K. ENDOCRINE SYSTEM AND METABOLIC CONDITIONS

1. General. Any abnormality that does not respond to therapy satisfactorily or where replacement therapy presents significant management problems.

2. Diabetes

a. All cases requiring oral hypoglycemics.

b. All cases requiring insulin and/or restrictive diet for control.

c. When individuals requiring insulin for maintenance are under poor control ("brittle diabetics").

3. Acromegaly.

4. Adrenal Hyper or Hypofunction.

5. Diabetes Insipidus.

6. Hyper or Hypothyroidism. When not controlled by accepted therapy.

7. Hyper or Hypoparathyroidism. Especially when residuals or complications of surgical treatment (renal, skeletal or mental alterations) prevent performance of duty.

8. Hyperinsulinism. When caused by malignancy or not readily controlled.

9. Gout. In advanced cases with frequent (>3/yr) acute exacerbations or severe bone, joint, or renal damage.

10. Osteomalacia. With residuals that prevent the performance of duties.

11. Hypogammaglobulinemia.

12. Hypercoagulable States.

13. Heat Injury

a. Recurrent Heat Exhaustion. Manifested by collapse, including syncope, occurring during or immediately following exercise or in an environment of increased heat. Must occur at least three or more times in twenty-four months. No remedial factor can be identified.

b. Heat Stroke. Hyperpyrexia (core temperature >106 degrees Fahrenheit), collapse, encephalopathy and organ damage and/or systemic inflammatory activation during the episode. In the absence of encephalopathy, exertional rhabdomyolysis and myoglobinuria are sufficient. A trial of duty may be recommended if complicating factors have been identified and there are no residuals.

L. NERVOUS SYSTEM

1. General. (To better measure conditions involving the nervous system, it is mandatory that certain yardsticks be employed. In DEMENTIA AND HEAD TRAUMA CASES , neuropsychiatric measurements should be performed as early as possible. In MIGRAINE CASES , the number of incapacitating episodes (those that require the individual to stop the activity in which engaged and seek medical treatment) per week, month or year should be noted and verified by a physician. In SEIZURE DISORDER CASES , the evaluation will be done by a neurologist. An EEG, MRI/CT will be included in the initial examination. When subsequent seizure episodes occur while on medical therapy, blood levels of prescribed medication(s) will be determined. All cases of neuropathies will have EMG and nerve conduction studies performed. Cases of multiple sclerosis will have an MRI. Estimation of the degree of social and industrial impairment incurred by the Service member due to migraine and seizure disorder should be included.)

2. Neurogenic Muscular Atrophy

a. Amyotrophic Lateral Sclerosis.

b. All Primary Muscle Disorders.

(1) Facioscapulohumeral Dystrophy.

(2) Limb Girdle Dystrophy.

(3) Myotonia Dystrophy.

c. Myasthenia Gravis. Other than solely ocular.

d. Polio.

3. Progressive Degenerative Disorders.

a. Parkinson's Disease.

b. Huntington's Chorea.

c. Hepatolenticular Degeneration.

d. Friedreich's Ataxia.

4. Demyelinating Disorders.

a. Multiple Sclerosis.

b. Optic Neuritis, recurrent or with residuals.

c. Transverse Myelitis.

5. Residuals of Cerebrovascular Accidents.

6. Residuals of Traumatic Brain Injury.

7. Headaches. Headaches, Migraine, Tension, Vascular, Cluster Types. When manifested by documented frequent incapacitating attacks.

8. Seizure disorders.

9. Narcolepsy.

10. Sleep Apnea Syndrome, when complicated by requirement for an appliance such as CPAP for control.

11. Peripheral Nerve Dysfunctions

a. Neuralgia. When severe, persistent, and not responsive to therapy.

b. Neuritis.

c. Paralysis.

12. Syringomyelia.

13. General Neurological Disorders. Any other neurological condition, regardless of etiology, when, after adequate treatment, residual symptoms prevent the satisfactory performance of duty.

M. PSYCHIATRIC DISORDERS

1. General

a. The terminology and diagnostic concepts used in this section are in consonance with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

b. The Multiaxial System of Diagnosis will be used for all psychiatric conditions that are the subject of an MEB:

AXIS I.	Clinical Psychiatric Disorders and Other Psychiatric conditions that may be a focus of clinical attention.
AXIS II.	Personality Disorders; Mental Retardation.
AXIS III.	General Medical Disorders
AXIS IV.	Psychosocial and Environmental problems.
AXIS V.	Global Assessment of Function (GAF).

c. All AXES I and II diagnoses will be assessed as to the Impairment for Military Duty as well as the Impairment for Social and Industrial functioning. This applies even though conditions normally placed on Axis II do not render a Service member medically unable to perform assigned duties. (See Enclosure 1 of DOD Instruction 1332.39 (reference (i)) on VASRD under "Psychoses".)

d. Personality, Sexual, or Factitious Disorders, Disorders of impulse control not elsewhere classified, Adjustment Disorders, Substance-related Disorders, Mental Retardation (primary), or Learning Disabilities are conditions that may render an individual administratively unable to perform duties rather than medically unable, and may become the basis for administrative separation. These conditions do not constitute a physical disability despite the fact they may render a member unable to perform his or her duties.

e. Any MEB listing a psychiatric diagnosis must contain a thorough psychiatric evaluation and include the signature of at least one psychiatrist (identified as such) on the MEB signatory face sheet.

2. Disorders with Psychotic Features (Delusions or prominent Hallucinations). One or more psychotic episodes, existing symptoms or residuals thereof, or a recent history of a psychotic disorder.

3. Affective Disorders (Mood Disorders). When the persistence or recurrence of symptoms requires extended or recurrent hospitalization, or the need for continuing psychiatric support.

4. Anxiety, Somatoform, Dissociative Disorders (Neurotic Disorders). When symptoms are persistent, recurrent, unresponsive to treatment, require continuing psychiatric support, and/or are severe enough to interfere with satisfactory duty performance.

5. Organic Mental Disorders. Dementia or organic personality disorders that significantly impair duty performance.

6. Eating Disorders. When unresponsive to a reasonable trial of therapy or interferes with the satisfactory performance of duty.

N. NEOPLASMS

1. Malignant Neoplasms

a. Malignancies which are unresponsive to therapy or whose residuals prevent satisfactory performance of duty.

b. When the service member with a malignant neoplasm refuses accepted therapy.

c. When, for a variety of reasons, a service member, who has been treated for a malignant neoplasm, will leave active duty before having had an adequate period of observation to determine whether a cure has been effected. These do not include basal cell carcinomas or small squamous cell carcinomas.

2. Benign Neoplasms. Usually benign tumors do not prevent satisfactory performance of duty.

a. When the Service member refuses accepted medical treatment.

b. Ganglioneuroma.

c. Meningeal Fibroblastoma.

d. Pigmented Villonodular Synovitis.

O. GULF WAR CASES

1. Comprehensive Clinical Evaluation Program (CCEP) participants who are diagnosed with conditions that are cause for referral into the DES shall receive a MEB to determine if the case is to be referred to the PEB. Referral of a CCEP participant can occur at any point during CCEP process once a condition which is cause for referral into the DES is identified. However, CCEP participants who have undiagnosed medical complaints should not be referred until they have completed Phase II of the CCEP protocol.

2. All disability cases that involve service members who have undergone any part of the CCEP shall include:

a. A medical board report, or addendum to an original medical board report, with a summary of the CCEP findings.

b. Copies of all CCEP documentation (e.g., test results, consultation reports, et al).

3. Failure to include the foregoing information in any case referred to the PEB for adjudication shall result in its return to the convening authority.

Attachment
Minimum Requirements For Medical Evaluation Board (MEB) Addenda and Narrative Summary With Annotations

MINIMUM REQUIREMENTS FOR MEDICAL EVALUATION BOARD (MEB) ADDENDA AND NARRATIVE SUMMARY WITH ANNOTATIONS

1. PURPOSE. This attachment details the minimum medical information requirements to be annotated in any Medical Evaluation Board or addendum. This information must be documented and approved prior to forwarding the case to the Physical Evaluation Board (PEB).

2. MEDICAL EVALUATION BOARD (MEB) DOCUMENTATION

a. Required Information

(1) Member's name, rank, grade, and social security number

(2) The specialty of the signatory physicians.

(3) The Clinical Department and/or Service.

(4) The Medical Treatment Facility and its location.

(5) Date Medical Evaluation Board (MEB) was conducted.

b. On each page:

(1) Member's Last name, last four digits of Social Security Number, and date typed or transcribed in bottom margin.

(2) Page number will be annotated at the bottom center of the page.

c. Reason for Doing the MEB (e.g., physician-directed, command-directed).

d. Service Member's Eligibility for MEB.

e. Military History

(1) Date of first and most recent entry into service.

(2) Estimated termination of Service.

(3) Administrative Actions ongoing, pending, or completed (e.g., Line of Duty Investigations, Courts-martial, Selective Early Retirement, Bars, Retirement or Separation Dates).

f. Chief Complaint. Preferably stated in Service member's own words.

g. History of Present Illness. Exact details, including pertinent dates regarding injuries, how incurred, and a statement

of the final Line of Duty (LOD) determination, if available. Enclose and summarize any pertinent previous MEBs.

h. Past Medical History

(1) Past injuries and illnesses.

(2) Prior disability ratings (e.g., given by the DES or Department of Veterans Affairs).

(3) Past hospitalizations and relevant outpatient treatment, including documentation of diagnosis and therapy, pertinent dates, and location should be listed.

(4) Social information should be provided which includes but is not limited to:

(a) Living arrangements (e.g., by oneself, with spouse and children, with parents and siblings).

(b) Marital status (single, married, separated, divorced, and the type of relationship (harmony or strife)).

(c) Leisure activity (sports, hobbies, TV, reading)

(d) Acquaintances (male, female, both sexes, many, few).

(e) Substance use or abuse (alcohol, drugs)

(f) Police encounters/record.

(5) Illnesses, conditions, and prodromal symptoms, existing prior to service (referred to as EPTS or EPTE conditions).

i. Laboratory Studies. All studies that support and quantify the diagnosis(es) should be included as should any studies that conflict with the diagnosis(es).

j. Present Condition and Current Functional Status

(1) The current clinical condition of the service member should be noted including required medications and any non-medication treatment regimens (e.g., physical therapy) in progress.

(2) Functional status.

(a) The Service member's functional status as to the ability to perform his or her required duty should be indicated.

(b) If possible, a summation of the member's ability to perform the civilian equivalent of their assigned duties should be indicated.

(3) A statement should be given regarding the prognosis for functional status after completion of treatment if chronic treatment is not necessary.

(4) A statement should be given regarding the prognosis for functional status in cases requiring chronic treatment.

(5) The stability of the current clinical condition and functional status should be addressed.

(6) Statement of compliance with treatment recommendations and reasonableness of any refusal of recommended treatment procedures.

(7) Requirement for monitoring including frequency of indicated treatment and/or therapy visits and associated operational assignment limitations.

k. Conclusions

(1) An informed opinion should be stated as to the Service member's ability to meet current Retention Standards.

(2) If a Service member does not meet Retention Standards, the specific reasons why should be stated.

(3) Treatment recommendations including medications, procedures, and behavior and/or lifestyle modifications. Include a statement concerning the member's compliance. If non-compliant, indicate whether the non-compliance is reasonable.

(4) Under no circumstances is the narrative to indicate the members is unfit, nor recommend a disability percentage rating. It is the PEB's responsibility to determine fitness and disability percentage ratings. The MEB may state something to the effect, "the member is referred to the PEB because we are of the opinion that the member's condition may interfere with the performance of his or her duties because the member does not meet medical retention standards as described in..."

l. Diagnosis(es). The diagnostic terminology used by the MEB should correlate, if at all possible, with that of the Veterans Affairs Schedule for Rating Disabilities (VASRD). Because the Physical Evaluation Boards are required to assess a Service member's status based on the VASRD, a clearer understanding of that status is facilitated when the same terminology is used by the MEBs and the PEBs.

m. Profile. (If required by service regulation).

(1) The Physical Profile of the service member should agree with the severity of the medical impairment as expressed in by the MEB.

(2) The Physical Profile (PULHES) of the SF-88 should agree with that of the Physical Profile Form as well as that noted in the MEB cover sheet.

3. PHYSICAL EXAMINATION (PE). A complete Physical Examination must be recorded in the MEB. For all conditions, hand dominance must be stated. Selected specialty-related considerations and guidelines follow.

a. Cardiology

(1) Results of special studies to support and quantify the cardiac impairment should be noted e.g. treadmill and thallium stress tests, angiography, and other special studies.

(2) It is imperative that the Functional Therapeutic Classification of the cardiac condition be included. Either the New York or Canadian classification system may be used.

b. Gastroenterology. Service members with fecal incontinence should have recorded findings of rectal examination e.g., digital exam, manometric studies as indicated, and radiographic studies. The degree and frequency of the incontinence should be noted as well as the incapacitation caused by the condition.

c. Neurosurgery

(1) For Vertebral Disc problems, radicular findings on PE should be supported by laboratory studies such as CAT scan, MRI, EMG, NCV. In cases where surgery has been performed, both pre- and postoperative deep tendon reflexes should be documented.

(2) For head injuries neuropsychiatric assessment should be accomplished in all head injury cases. Results of any clinically indicated neuropsychological testing should be included.

d. Ophthalmology. If retention standards are not met for reasons related to vision, visual fields must be included in the PE and verified by an ophthalmologist. Specialist examination should include uncorrected and corrected central visual acuity. Snellen's test or its equivalent will be used and if indicated measurements of the Goldman Perimeter chart will be included.

e. Orthopedics

(1) Range of Motion (ROM) measurements must be documented for injuries to the extremities. The results of the

measurement should be validated and the method of measurement and validation should be stated.

(2) In cases involving back pain, the use of Waddell's signs should be included in assessing the severity and character of the pain. (Waddell G, McCulloch JA, Kummel E, Venner RM. Non-organic physical signs in low back pain. Spine. 1980;5:117-125. Waddell G. Somerville D, Henderson I, Newton M. Objective clinical evaluation of physical impairment in chronic low back pain. Spine. 1992;17:617-628.)

f. Otolaryngology: Audiograms must include speech discrimination scores.

g. Psychiatry (Also refer to pages 4-20/21 paragraph M)

(1) Particular attention should be paid to documenting all prior psychiatric care. Supportive data should be obtained for verification of the patient's verbal history.

(2) Psychometric assessment should be carried out if such assessment will help quantify the severity of certain conditions and allow a reference point for future evaluation.

(3) The Diagnostic and Statistical Manual of Mental Disorders (most recent edition) will be used for diagnostic terminology. The Multiaxial System of Assessment will be used to include Axes I-V. The degree of industrial and industrially related social impairment must be individually determined and documented, for each Axis I and Axis II diagnosis, and correlated to the Service member's clinical manifestations. Increased severity of symptoms due to transient stressors associated with the PEB and prospect of separation or retirement and relocation or re-employment will not be considered in determining the degree of impairment. In addition relationship of the impairment to military and civilian performance is required. The service member's total impairment for civilian industrial adaptability from all sources (Axes I, II, III) should be determined and documented. The contribution of each condition to the total adaptability impairment should then be individually noted and correlated with the service member's clinical manifestations.

(4) Every effort must be made to distinguish symptoms and impairment resulting from personality disorder or maladaptive traits from impairments based on other psychiatric conditions.

h. Pulmonary. When an MEB is held for restrictive or obstructive pulmonary disease, documentation will be provided of pulmonary function testing carried out when service member is on and off therapeutic medication. There must be three pulmonary function tests (PFTs) done off medication, two of which must be in agreement within the five percent (5%) level, and three done

on medication, two of which must agree within the five percent level.

i. Urology

(1) Cases involving neurogenic bladder must include studies that document the condition.

(2) All cases involving incontinence must include studies that document the condition.

(3) Cases involving incontinence and/or neurogenic bladder should have documentation regarding severity as indicated by the number of times self-catheterization is required, the number and type of pads required in a day, or the soilage frequency.

CONDITIONS NOT CONSTITUTING A PHYSICAL DISABILITY

1. PURPOSE. To detail conditions which do not constitute a physical disability.

2. GENERAL CONSIDERATIONS

a. Certain conditions and defects of a developmental nature designated by the Secretary of Defense do not constitute a physical disability and are not ratable in the absence of an underlying ratable causative disorder. If there is a causative disorder it will be rated in accordance with other provisions of this Instruction.

b. These conditions include but are not limited to those listed in paragraph 3., below.

c. Such conditions should be referred for appropriate administrative action under other laws and regulations.

3. DEVELOPMENT DEFECTS AND OTHER SPECIFIC CONDITIONS

a. Enuresis

b. Sleepwalking and/or Somnambulism

c. Dyslexia and Other Learning Disorders

d. Attention Deficit Hyperactivity Disorder

e. Stammering or Stuttering

f. Incapacitating fear of flying confirmed by a psychiatric evaluation

g. Airsickness, Motion, and/or Travel Sickness.

h. Phobic fear of Air, Sea and Submarine Modes of Transportation

i. Certain Mental Disorders including:

(1) Uncomplicated Alcoholism or other Substance Use Disorder

(2) Personality Disorders

(3) Mental Retardation

(4) Adjustment Disorders

(5) Impulse Control Disorders

(6) Homosexuality

(7) Sexual Gender and Identity Disorders, including Sexual Dysfunctions and Paraphilias

(8) Factitious Disorder

j. Obesity.

k. Overheight.

l. Psuedofolliculitis barbae of the face and/or neck.

m. Medical Contraindication to the Administration of Required Immunizations.

n. Significant allergic reaction to stinging insect venom.

o. Unsanitary habits including repeated venereal disease infections.

p. Certain Anemias (in the absence of unfitting sequelae) including G6PD Deficiency, other inherited Anemia Trait, and Von Willebrand's Disease.

q. Allergy to Uniformed Clothing.